☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

SCHOOL-BASED HEALTH CENTER

HEALTH HISTORY FORM

CHC Community Health Center OF SNOHOMISH COUNTY

Please complete this form to help us provide your child with quality care. Your child will be invited to the health center for a health screening to review their weight, height, blood pressure and immunization history, and complete a health risk assessment. The health center will contact you about any recommendations for supporting your child's health and readiness to learn. Additional consent from a parent/guardian is required before giving any vaccines. Please contact the health center if your child has a health issue and needs an appointment.

STUDENT	First Name	Last Name	Date of Birth / /
Printed Name of Person Completing Form		Relationship to Student (if not self)	Date Form Completed / /
Best Phone Number to Reach you		Best Time to Call	

QUESTIONS ABOUT YOUR CHILD:

❑ Yes ❑ No Does your child have a primary care doctor or clinic?
Provider Name: Clinic: Phone:

❑ Yes ❑ No Has your child had a well child check up or full physical in the past year?

❑ Yes ❑ No Has your child seen a dentist in the past year?

❑ Yes ❑ No Does your child have any medication or other allergies?
(Describe):

❑ Yes ❑ No Does your child take any medications? (Include vitamins and over-the-counter medications.)

Medication	Dosage	Reason

❑ Yes ❑ No Does your child have any ongoing health problems or current health concerns?
(Describe):

❑ Yes ❑ No Has your child ever stayed in a hospital or had surgery?
(Describe):

❑ Yes ❑ No Does your child have any school/learning needs or concerns?
❑ Attendance problems ❑ Worse or failing grades ❑ Special Education ❑ Other:

❑ Yes ❑ No Do you have other concerns about your child's well being? (ex: too much worry, stress, depression, anxiety, etc.)
(Describe):

QUESTIONS ABOUT YOUR FAMILY:

Who lives in your home?

If your child also lives in another home, who lives there?

❑ Yes ❑ No Have there been any major changes or challenges in your family in the past year?
If yes, describe:

❑ Yes ❑ No Does anyone living with your child smoke cigarettes, cigars, e-cigarettes, or marijuana?

❑ Yes ❑ No Are you concerned there will not be enough food or money to feed your family?

❑ Yes ❑ No Is there a gun in your home? If yes, is it locked? ❑ Yes ❑ No

❑ Yes ❑ No Is your child adopted?

FAMILY HEALTH HISTORY (*Check all that apply*)

Family Member	No Known Problems	Alcohol/Drug Abuse	Arthritis	Asthma	Cancer	Heart Problems	Depression	Diabetes	High Cholesterol	Hypertension	Kidney Disease	Mental Illness	Stroke	Vision Problems
Mother														
Father														
Other Family Member:														
Other Family Member:														

Is there any other family history of disease or chronic illness?

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SCHOOL-BASED HEALTH CENTER

PATIENT REGISTRATION FORM

CHC Community Health Center OF SNOHOMISH COUNTY

Please fully complete this form to help us provide your child with quality care. This consent will remain active from year to year. Please submit a request in writing to withdraw consent for services. Due to the non-profit status and funding source for Community Health Center of Snohomish County (CHC), we are required to ask these registration questions (in gray). You have the right to refuse to answer any of these questions. The information you provide will not be shared or used for any purpose other than to gather general demographic data to better serve our community.

Please complete sections 1–6.

1. STUDENT INFORMATION AND DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST

STUDENT ID NUMBER	DATE OF BIRTH / / MONTH DATE YEAR	BIRTH SEX ❑ Male ❑ Female	LEGAL SEX ❑ Male ❑ Female ❑ Nonbinary

MAILING ADDRESS	APT	SECONDARY ADDRESS (if different)	APT

CITY	STATE	ZIP	CITY	STATE	ZIP

PARENT PHONE ❑ Home ❑ Mobile ❑ Work __ __ __ – __ __ __ – __ __ __ __	STUDENT PHONE ❑ Home ❑ Mobile ❑ Work __ __ __ – __ __ __ – __ __ __ __
PARENT E-MAIL ADDRESS	STUDENT E-MAIL ADDRESS
APPOINTMENT NOTIFICATION PREFERENCE (choose one) PARENT ❑ Text ❑ Phone Call	APPOINTMENT NOTIFICATION PREFERENCE (choose one) STUDENT ❑ Text ❑ Phone Call

GENDER IDENTITY	❑ Female ❑ Male ❑ Questioning	❑ Transgender Male to Female ❑ Transgender Female to Male ❑ Nonbinary/Gender Queer	❑ Other _____ ❑ Choose not to disclose
SEXUAL ORIENTATION	❑ Straight ❑ Gay	❑ Lesbian ❑ Queer	❑ Bisexual ❑ Pansexual	❑ Other:_____ ❑ Choose not to disclose
PREFERRED PRONOUN	❑ She, Her, Hers ❑ He, Him, His	❑ They, Them, Theirs ❑ Other:	❑ Choose not to disclose
ARE YOU HISPANIC OR HISPANIC-LATINO?	❑ Yes, Hispanic or Latino	❑ Not Hispanic or Latino	❑ Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ More than one race	❑ Asian ❑ Other Pacific Islander ❑ Declined to identify	❑ Black/African American ❑ White
ARE YOU A US VETERAN?	❑ Yes ❑ No		
WHAT IS YOUR EMPLOYMENT STATUS?	❑ Full Time ❑ Part Time ❑ Seasonal	❑ Child ❑ Not Employed ❑ Active Military Duty	❑ Self Employed ❑ Retired ❑ Student
WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?		DO YOU NEED AN INTERPRETER?	❑ Yes ❑ No

2. PARENT/GUARDIAN (IF PATIENT IS UNDER 18)

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME	DATE OF BIRTH / /	SEX ❑ Male ❑ Female

MAILING ADDRESS	APT	RELATIONSHIP TO PATIENT ❑ Parent ❑ Guardian ❑ Other

CITY	STATE	ZIP	PHONE ❑ Home ❑ Mobile ❑ Work __ __ __ – __ __ __ – __ __ __ __

This form continues on reverse. Please complete all sections. ➲

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SCHOOL-BASED HEALTH CENTER
PATIENT REGISTRATION FORM

CHC Community Health Center OF SNOHOMISH COUNTY

Continued from reverse.

3. INSURANCE

DO YOU HAVE INSURANCE?	❑ Yes ❑ No			
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE		EFFECTIVE DATE	
	GROUP PLAN NUMBER		MEMBER ID #	
	SUBSCRIBER/POLICY HOLDER NAME		SUBSCRIBER DATE OF BIRTH	
ARE YOU INTERESTED IN OUR SLIDING FEE DISCOUNT PROGRAM?	We offer a sliding fee discount if you do not have health insurance or need help paying for expenses that health insurance does not cover. Eligibility for the program and the minimum fee is based on your family size and income. For more information and to apply, would you like to meet with one of our eligibility specialists?		❑ Yes ❑ No	

4. ADDITIONAL QUESTIONS (Answer for patient or, if patient is a minor, please answer for legal guardian.)

YEARLY OR MONTHLY INCOME	What is your household's annual (yearly) gross income?	$	If easier to calculate, what is your household's monthly income?	$
TOTAL NUMBER IN HOUSEHOLD	Number of family members reported on federal income tax return:			
ARE YOU HOMELESS OR IN A TEMPORARY SHELTER?	❑ Not Homeless ❑ Doubling Up ❑ Other ❑ Permanent Supportive Housing ❑ Public Housing ❑ Shelter ❑ Street ❑ Transitional			
MIGRANT/SEASONAL WORK STATUS	At any point in the past two years, has seasonal or migrant farm work been your or you family's main source of income?		❑ No Farm Work ❑ Yes, Migrant Farm Work ❑ Yes, Seasonal Farm Work	
HOW DID YOU HEAR ABOUT NEIGHBORCARE HEALTH? (Mark all that apply)	❑ Friends or family ❑ Insurance ❑ Online search (Google) ❑ Other non-Neighborcare provider ❑ Convenient location/close to home ❑ Other community group or program ❑ Social media (Facebook, Twitter, Instagram) ❑ Ads (billboard, bus, newspaper) ❑ School ❑ Other			

5. PRIVACY NOTICE

I hereby acknowledge I have received CHC's Notice of Privacy Practices. I understand CHC of Snohomish County may contact me about appointment reminders, test results, treatment options or other health related benefits and services via phone call, text message, e-mail, or voicemail.	Initials

6. RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to CHC is currently correct, and I understand that any deliberate misrepresentation of the information may cause me to be responsible for full charge of services delivered. I grant permission to the medical, mental health and dental staff to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of my health problem(s). I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant or other licensed staff. I understand that the mental health care may be given by a Licensed Social Worker, Licensed Mental Health Counselor, or other licensed staff. I understand that dental care may be given by licensed Dentists, Dental Hygienists, Dental or Hygiene students or trained volunteers in accordance with the Washington State Dental Practice Act. This authorization shall remain in effect unless the consent is canceled by written notice to the Chief Medical/Dental Officer. The assignment and release authorizes CHC to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly any benefits of any policies of insurance to those health care providers who have rendered services to me. I agree to pay in full all charges that are not paid in full by assigned insurance.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE
		/ /

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SCHOOL-BASED HEALTH CENTER

CONSENT FOR HEALTH SERVICES

CHC Community Health Center OF SNOHOMISH COUNTY

CHC's school-based health centers are located in Edmonds school district. CHC must have signed consent from a parent or legal guardian before providing services, except in situations where federal or state laws allow the student to access treatment without parent/guardian consent. Students do not need to be registered at the health center to receive services from the school nurse.

I hereby request and authorize that: (Print student's name below.)

First Name	Middle Initial	Last Name	Date of Birth
			/ /

receive health care services available from and deemed necessary by the CHC SBHC staff. These services may include, but are not limited to: mental health counseling, routine medical exams, naturopathy, sports physicals, well-child or teen care, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs, X-rays, dental and fluoride treatment services. SBHC staff encourage family involvement in the care they provide to students. However, if I am unable to be present, authorization is given for my child to receive services in my absence. This care may occur both in-person or remotely via phone or virtual telehealth visit. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the CHC SBHC staff. This authorization does not allow services to be rendered without the student's consent, unless the student is unable to consent. CHC is committed to creating a health care home that includes medical, dental and mental health care and CHC encourages long-term relationships between patients and providers. CHC collaborates with other providers in the community that may also be seeing the patients we serve to ensure care is coordinated.

In accordance with state and/or federal law, when consent is provided for care, health care information is kept confidential. A few exceptions exist; for example:

1. Permission is given by the patient or parent/guardian through a signed release of information form.
2. The patient indicates risk of imminent harm to self or others.
3. The patient has a life-threatening health problem and is under the age of 18.
4. There is reason to suspect abuse or neglect.
5. Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information with the health care providers at the SBHC, including exchange of information between the mental health therapist, nurse practitioner or physician assistant and the school nurse, for the purpose of providing the best care for the above named student. To facilitate coordination of care, the student's SBHC medical record will be accessible to CHC staff at the SBHC. Consent is granted for the school nurse to administer over-the-counter medications (for example, Ibuprofen, Tylenol, Tums, etc.) as prescribed by the medical provider of the SBHC.

Students may also receive health services independently at any of CHC's medical or dental clinics. With this consent, services can be received at any CHC of Snohomish County medical and dental clinic. To see a list of clinic locations, please visit our website at chcsno.org. To schedule an appointment, call CHC at 425-789-3789

Consent is authorized for services provided by CHC during the length of time the student is enrolled in a school with a CHC SBHC or for the length of time services are provided at another CHC clinic. Withdrawal of this consent can be done at any time by writing to the SBHC.

Student Signature: *(Required for 13 and older)*	Date: / /
Parent/Guardian Signature:	Date: / /
Name of Legally Responsible Guardian (Print):	Relationship:

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

Under Washington State law, the SBHC will provide and assist students in accessing outside care if necessary. Under Washington State law, youth may independently access reproductive health care at any age without parent/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health counseling without parent/guardian consent. The SBHC encourages students to involve their parents or guardians in health care decisions whenever possible. When applicable, the SBHC will assist the student in discussing these situations with parents/guardians.

Because youth are able to provide consent for treatment, their consent is legally required for release of information about pregnancy and sexually transmitted diseases (including HIV/AIDS testing). Consent from students age 13 and older, and parent/guardian consent for students age 12 and younger, is legally required for release of information about alcohol and drug or mental health counseling. For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent."

SCHOOL-BASED HEALTH CENTER

DENTAL SCREENING CONSENT

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
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CHC Community Health Center OF SNOHOMISH COUNTY

SCHOOL:	CLASSROOM #:	MRN: (For Administrative Use)

DEAR PARENT OR GUARDIAN:

We are offering dental screenings in your child's school to inform you about your child's dental health. The screenings have **no out of pocket cost to you.**

If you agree to have us screen your child:

- Dental screenings will resume when students return for in-person learning.
- We will be happy to give you information to make a dental appointment, or make an appointment for you, if you need a dental provider.
- We will send you a copy of your child's results. This information may be shared with your child's school.
- We may leave a message on your phone if we need to contact you about your child's dental needs.

WHAT IS A DENTAL SCREENING?

A CHC dental provider will look at your child's teeth and make a **visual evaluation.**

They will apply a **fluoride varnish** which is a protective coating that is painted on teeth to help prevent new cavities and to help stop cavities that have already started.

A dental screening **does NOT take the place of a complete dental exam** by your child's dentist.

Parents or Guardians, please fill out the information below and sign the bottom of the form.

NAME OF STUDENT:			
FIRST NAME	MI	LAST NAME	DATE OF BIRTH / /
GENDER OF STUDENT: ❑ Male ❑ Female ❑ X			

NAME OF PARENT/GUARDIAN:			
FIRST	MI	LAST	DATE OF BIRTH / /
ADDRESS:		CITY:	ZIP:
PHONE #:			

Do you prefer to be contacted in a language other than English?	❑ No ❑ Yes	If yes, what language?
How would you like to receive your child's dental evaluation results?	❑ Please give them to my child at school to take home. ❑ Please mail them to the address listed above.	
When did your child last see a dentist?	❑ Less than 6 months ago ❑ Less than 2 years ago ❑ Less than 1 year ago ❑ More than 2 years ago ❑ Never	
Does your child have a regular dentist?	❑ No ❑ Yes	If yes, where?
Would you like help finding a dentist for your child?	❑ No ❑ Yes	

This program is without cost to you, but your health insurance company may be billed for services. Please complete the insurance section of this form to ensure we have the most current information. Public insurance plans generally cover the entire fee of the screening. If any costs are not covered by insurance, they will be covered by grants. No out-of-pocket expense will be billed to any student or family participating in the program. The screening will not be billed as one of your child's two yearly dental exams.

PLEASE LIST YOUR APPLE HEALTH OR OTHER DENTAL INSURANCE INFORMATION BELOW:					
DENTAL INSURANCE NAME:					
SUBSCRIBER NAME:					
RELATIONSHIP:		SUBSCRIBER GENDER:		SUBSCRIBER DOB:	/ /

BY SIGNING THIS FORM YOU AGREE TO TWO DENTAL SCREENINGS AND FLUORIDE VARNISHES.

SIGNATURE OF PARENT OR GUARDIAN	DATE

Notice of Privacy Practices

This Notice is effective on May 23, 2013

We maintain protocols to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits and virus/intrusion detection software. Within our practice, access to your information is limited to those who need it to perform their jobs.

Community Health Center of Snohomish County is committed to treating and using protected health information about you responsibly. This Notice of Privacy Policies describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective May 23, 2013, and applies to all protected health information as defined by federal regulations.

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Promise to You, Our Patients: *Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.*

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the Privacy Practices that are described in this Notice (which may be amended from time to time).

For more information about our Privacy Practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

Right to Obtain Notice: You have the right to obtain a paper copy of this Notice by submitting a request to Community Health Center of Snohomish County, 8609 Evergreen Way, Everett, WA 98208 at any time.

Right to Receive Notification of a Breach: We are required to notify you if we discover a breach of your unsecured PHI, according to requirements under federal law.

Questions or Complaints: If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact our Compliance Office Privacy line at 425-789-3774. You may also file a written complaint with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director or with our office. If you believe your privacy rights have been violated, you can either file a complaint with our office or with the Office for Civil Rights, U.S. Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our practice or the OCR. The address for the OCR regional office for Washington is as follows:

Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue – M/S: RX-11
Seattle, WA 98121-1831

Changes to this Notice: We may change the terms of this Notice at any time. If we change this Notice, we may make the new Notice terms effective for all PHI that we maintain, including any information created or received prior to issuing the new Notice. If we change this Notice, we will post the revised Notice in the waiting area of our office and on our web site at www.chcsno.org. You may also obtain any revised Notices by contacting Community Health Center of Snohomish County by mail at 8609 Evergreen Way, Everett, WA 98208.