

Eagles Health Clinic (SBHC) 2024-2025 Enrollment Form

**Signature REQUIRED for your child to be seen at the School Based Health Center (SBHC)*

Student Name: _____ Date of Birth: ____/____/____
First Name M.I. Last Name

Race: ☐ White ☐ Black/African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaskan Native ☐ Two or More Races ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Gender: _____ Grade: _____

Street Address: _____

Town: _____ State: _____ Zip: _____

Parent/Guardian #1 (Name/Relationship): _____

Address of parent (if different) _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Preferred Method of Communication (for non-emergencies): ☐ Email ☐ Phone

Parent/Guardian #2 (Name/Relationship): _____

Address of parent (if different) _____

Primary Phone: _____ Secondary Phone: _____

Email: _____

Preferred Method of Communication (for non-emergencies): ☐ Email ☐ Phone

Doctor/Primary Care Provider: _____ Phone: _____

Preferred Pharmacy: _____ Town: _____ Phone: _____

Medical Insurance Provider: _____

I give permission for my child _____ to use the School-Based health Center. I understand that this consent will remain in effect until the student's graduation or withdrawal from school. ***I also understand that I may revoke my consent at any time with written notification.*** I understand that my signature gives permission for the SBHC staff to access my child's school health record, share health information with my child's Primary Care Provider or Dentist and share information with the School Nurse, School Social Worker/Behavioral/Mental Health Therapist, School Counselor or contracted mental professional, when it is deemed appropriate for treatment purposes. I understand that the SBHC services are meant to compliment and not replace those provided by my child's Primary care Provider and all health related information will be treated in a confidential manner. I give permission for the Nurse Practitioner, School Nurse and clinic staff to administer needed medications. I give permission for the Nurse Practitioner to conduct a health assessment with my student. I understand that to provide health care for a student, the School Nurse and staff of the SBHC may share information about my child's health and health history. I understand that my signature indicates that I have a received a copy of the Notice of Privacy Practices.

Parent/Guardian Signature: _____ Date: ____/____/____

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Student Health Information

Please list below any known medical issues or special health concerns. Please include significant past illnesses, injury or hospitalizations.

Current Health Problems

Date of Last Eye Exam: ____/____/____ Glasses: Yes No Contacts: Yes No

History of Hearing Problems: Yes No Wears Hearing Aids: Yes No

Date of Last Tetanus Shot: ____/____/____ Date of Last Complete Physical Exam: ____/____/____

Date of last Dental Appointment: ____/____/____ Dentist: _____ Dentist Phone: _____

Family Health History

Please indicate where there is a family history of any of the following health conditions:

- | | | | |
|---|--|---|--|
| ☐ Heart Attack | ☐ Heart Disease | ☐ High Blood Pressure | ☐ High Cholesterol |
| ☐ Allergies | ☐ Asthma | ☐ Sickle Cell Disease | ☐ Mental Illness |
| ☐ Seizure Disorder | ☐ Cancer | ☐ Diabetes | ☐ Tuberculosis |
| ☐ Alcohol or Drug Abuse | ☐ Immune System Disorder | | |

Current Medications & Dosages

Medication Name: _____ Dose: _____

Medication Name: _____ Dose: _____

Medication Name: _____ Dose: _____

Medication Name: _____ Dose: _____

Anaphylaxis reaction(s) _____

Medication Allergies: _____