



SCHOOL BASED HEALTH CENTER AT HAMDEN HIGH SCHOOL PERMISSION/REGISTRATION FORM

Quinipiack Valley Health District has partnered with Cornell Scott-Hill Health Corporation to operate the school based health center (SBHC) at Hamden High School (formerly called "MOM'S clinic"). Students must be enrolled in the school's health center to receive services. The SBHC providers do not replace your child's regular health/mental health providers nor do they replace the role of the school nurse. The SBHC is open during school hours so that students and parents do not need to miss school or work. All services are free to students (no cost/fees to families) though billable services will be submitted directly to your insurance company. All students under the age of 18 must have a parent permission form completed and signed by the parent/guardian to receive services in the SBHC. Confidentiality between student and the health provider will be ensured in specific service areas in accordance with the law, and the students will be encouraged to involve their parents or guardians in counseling and medical care decisions.

SBHCs are staffed by a team of licensed professionals that include a medical provider (Nurse Practitioner or Physical Assistant), a social worker and a medical assistant. The medical provider offers preventative medical services like immunizations, physical exams, and sports physicals and acute care visits to diagnose, treat and follow up on illness or injury. The social worker provides assessments, individual/group/family counseling, student support groups, crisis intervention, and short/long term therapy as needed. All SBHC providers work closely with community providers, the school nurse and school staff to ensure that students get the care they need at school, or through community support services. TO ENROLL IN SERVICES, PLEASE FILL OUT ONE ENTIRE PACKET AND SIGN FOR EACH STUDENT.

STUDENT INFORMATION:

Patient's name: _____ Date of Birth: _____
Patient's Cell Phone: _____ Patient's Email: _____
Sex: _____ Female _____ Male _____ Other _____ Patient's Social Security Number: _____
Address: _____ City: _____ Zip Code _____
Patient's Ethnicity: _____ Hispanic/Latino _____ Not Hispanic/Latino
Patient's Race: _____ Black/African American _____ White _____ American Indian or Alaskan Native _____ Asian _____ Other _____ Unknown
Name of Primary Care Provider: _____ Phone: _____
Name of Dentist: _____ Phone: _____
Preferred Pharmacy Name/Address: _____

PARENT/GUARDIAN INFORMATION:

Parent/Guardian name: _____ Relationship: _____
Parent Cell Phone: _____ Parent Home Phone: _____ Parent Work Phone: _____
Parent's Email: _____ Preferred Language: _____ Need Interpreter?: _____
Parents: _____ Married _____ Divorced _____ Separated _____ Mother Deceased _____ Father Deceased _____ Single
Who lives with the student: _____ Mother _____ Father _____ Stepparent _____ Sisters _____ Brothers _____ Other: _____
EMERGENCY CONTACT (Please provide the name of 2 adults to notify in an emergency if parents are unavailable)
Contact Name: _____ Phone: _____ Relation: _____
Contact Name: _____ Phone: _____ Relation: _____

STUDENT INSURANCE INFORMATION:

Type of Health Insurance: _____ Medicaid _____ HUSKY A _____ HUSKY B _____ Private/Commercial _____ Dental _____ No Insurance
MEDICAID OR HUSKY INSURANCE: ID #: _____ Name of Managed Care Health Plan _____
PRIVATE/ COMMERCIAL INSURANCE: Insurance Company Name: _____ ID#: _____
Insurance Company Address (On back of card): _____
Policy Holder Name: _____ Policy Holder DOB: _____ Relation to Patient _____
Policy Holder Employer Name and Address: _____
Policy Holder Occupation: _____ Policy Holder SSN: _____

STUDENT HEALTH INFORMATION:

Please answer each question and explain for any "YES" answers:

1. Allergy to Food or Medication: _____
2. Name of medications taking regularly: _____
3. Chronic Health conditions such as asthma, diabetes, depression: _____
4. Hospitalization, surgery or major illness: _____
5. Significant injury or accident: _____
6. Any problems with vision/hearing/dental or speech problems? _____
7. Has the patient ever been referred for counseling? _____
8. Does the patient have any emotional, social or behavioral problems? _____
9. Does the patient have school attendance problems? _____
10. Has the patient experienced a major stress event in the past year such as a move, loss of or illness of loved one, bullying, violence? _____
11. Do you have any questions or concerns regarding the patient's health:

SCHOOL HEALTH CENTER SERVICES AVAILABLE TO ENROLLED STUDENTS:

- School Physical Exams/Sports Physicals
- Diagnosis and Treatment of Minor Illness/Injuries
- Treatment of Asthma, Anemia, Acne and other health problems
- Nutrition and Weight Counseling
- Referral for Specialty Care
- Immunizations
- Mental Health Individualized and Group Counseling
- Issue-Orientated Support Groups
- Crisis Intervention
- HIV/AIDS/STD Education, Counseling & Testing
- HIV/STD Prevention (including condom availability)
- Pregnancy Testing
- Reproductive Health
- Substance Abuse Education/Counseling

PARENTAL PERMISSION:

I have read the materials supplied to me regarding the services of the School Based Health Center and I give permission to the above named student to use the services provided by the School Based Health Center for as long as she/he is enrolled in the Hamden Public Schools. As the parent/guardian of the above, I understand that I may revoke the permission at any time for any reason and that I may add to or subtract from the services I do not want my child to receive by informing the School Based Health Center in writing that I wish to withdraw or change my permission/instructions. I give the SBHC staff permission to communicate with key school personnel if needed, to facilitate quality case management. Furthermore, I give permission to the SBHC to release information regarding treatment and/or services to the above insurance providers for purposes of billing. I authorize payments to be made directly to the agency providing services. I also acknowledge receipt of the SBHC Privacy Notice.

Parent/Guardian Signature

Date

Notice of Privacy Practices

Protection of your privacy is important to us. Please read about your health information privacy rights as a patient within this notice. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

For More Information, please Contact:

Deirdre Moody, Privacy Officer
Cornell Scott-Hill Health Corporation, 400 Columbus Avenue, New Haven, CT 06519
203-503-3153

Who We Are: This Notice describes the privacy practices of the Cornell Scott-Hill Health Corporation (CS-HHC), which include the privacy practice of:

- all of our doctors, nurses and other health care professionals authorized to enter information about you in your medical chart
- all of our departments, including our medical records and billing departments
- all of our health center sites, outreach programs, patient care facilities or programs operated by CS-HHC and
- all of our employees, staff, volunteers and other personnel who work for us or on our behalf.

Our Pledge: We understand that health information about you and the healthcare you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records and about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information.

We are required by law to:

- make sure that health information that identifies you is kept private
- give you this notice of our legal duties and privacy practices with respect to your personal health information
- notify affected individuals following a breach of unsecured protected health information and
- follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Health Information

We may use and disclose your personal health information for these purposes:

Treatment: To provide you with health care treatment or services. We may disclose health information about you to the doctors, nurses, technicians, medical students and others who are involved in your care. They may work at the CS-HHC, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for treatment, consultation, x-rays, lab tests, prescriptions or other health care services. They may also include doctors and other health care professionals who work at the CS-HHC or elsewhere who consult your care. For example, we may disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.

Payment: To bill and collect payment for you, your insurance company, including Medicare and Medicaid, or other third party that may be available to reimburse us for some or all of your health care, we may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to in order to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

Operations: For our day-to-day operations we may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses and disclosures are necessary to run the CS-HHC and to make sure that all of our patients receive quality care and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services the CS-HHC should offer, what services are not needed, whether new treatments are effective, or to compare how we are doing compared to others and to see where to make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our patients are.

Appointment Reminders: To contact you as a reminder that you have an appointment. Unless you direct us otherwise, we may send you reminders via mail, text message, email, or telephone call (including voicemail).

Health-related Services and Treatment Alternatives: To tell you about health-related services or recommended treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.

Individuals Involved in Your Care or Payment for Your Care: Unless you direct us otherwise, we may release health information about you to a friend or family member who is involved in your health care or the person who helps pay for your care with written authorization, in emergency situations or otherwise authorized by law.

Research: Under certain circumstances, we may use and disclose health information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will be approved through this special approval process, although we disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, as long as the health information they review does not leave our facility. We will always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.

Organ or Tissue Donation: If you are an organ donor, we may disclose your health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

As Required by Law: When required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: When necessary to prevent a serious threat to your safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help the imminent threat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information as required by military command authorities or the Department of Veteran Affairs as applicable. We may also release information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: For workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health and Safety Activities:

These activities generally include:

- to prevent or control disease, injury or disability
- to report births and deaths
- to report child abuse or neglect
- to report reactions to medications or problems with products
- to notify people of recalls of products
- to notify a person who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition
- to notify the appropriate government authority if we believe a patient has been the victim of abuse or neglect. We will only make this disclosure when required or authorized by law.

Abuse, Neglect, or Domestic Violence: We may notify the appropriate government authority if we believe you have been the victim of abuse or neglect. We will only make this disclosure when required or authorized by law or if you agree to the disclosure.

Health Oversight Activities: For activities authorized by law, which include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: In response to a court or administrative order, in response to a subpoena, discovery request or other lawful process that is not accompanied by a court or administrative order, but only if efforts have been made to obtain an order to protect the information requested, or you have given written authorization to the person requesting the information.

Law Enforcement: If asked to do so by law enforcement officials:

- in response to a court order, subpoena, valid search warrant, or similar process
- about criminal conduct at the CS-HHC
- in emergency circumstances to report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: This may be necessary, for example, to identify a deceased person or determine the cause of death. Also, funeral directors may need information to carry out their duties.

National Security and Intelligence Activities: To authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others: To authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Psychiatric Records and Communications: In the event that information released constitutes privileged psychiatric-patient communications, the confidentiality of this record is required under chapter 899 of the Connecticut General Statutes. This material shall not be transmitted to anyone without written authorization as provided in the aforementioned statutes.

Drug and Alcohol Abuse Records: In the event that information is protected by the Confidentiality of Alcohol and Drug Abuse Patient Records regulations. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

HIV Related Information: In the event that the information released constitutes confidential HIV-related information protected under Connecticut law. This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Disclosures Where Authorization Required: Except as permitted by law, your authorization is required prior to any disclosure of personal health information for marketing or sales purposes or prior to any disclosure of psychotherapy notes.

YOUR RIGHTS:

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Right to Inspect and Copy: You have the right to inspect and copy the personal health information in your medical and billing records, or in any group of records that we maintain and use to make health care decisions about you.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the same person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information we maintain about you. To request an amendment, your request must be made in writing and submitted to our privacy contact person identified on the first page of this notice. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or organization that created the information is no longer available to make the amendment.
- is not part of the health information kept by or for the Cornell Scott-Hill Health Corp.
- is not part of the information which you would be permitted to inspect or copy, or
- we believe is accurate and complete.

Any amendment we make to your health information will be disclosed to the health care professionals involved in your care and to others to carry out payment and healthcare operations, as we previously described in this notice.

- **Right to Receive an Accounting of Disclosures:** You have the right to receive an accounting of certain disclosures of your health information that we made.

Any accounting will not include all disclosures that we make. For example, an accounting will not include disclosures:

- pursuant to your written authorization
- to a family member, other relative, or personal friend involved in your care or payment for your care when you have given us permission to do so
- to law enforcement officials

To request an accounting of disclosures, you must submit your request in writing to our privacy contact person identified on the first page of this notice. Your request must state a time period, which may not be more than six (6) years prior to the date of your request. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list. This date will not exceed 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit or restriction on the health information we have been previously authorized to disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you may request that we do not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we agree, however, we will comply with your request unless the information is needed to provide emergency treatment. We must agree to your request to limit disclosure of protected health information about you to a health plan if the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law and the protected health information pertains solely to a health care item or service for which you or someone other than the health plan has paid us in full. To request a restriction, you must make your request in writing to our privacy contact person identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Receive Confidential Communications: you have the right to request that we communicate with you about health matters in a certain way. For example, you can ask that we only contact you at work or by mail to a specified address.

To request we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to Notification: You have the right to notify this Center if your personal health information has been breached.

Right to direct access to your lab results: You have the right to receive a copy of any laboratory results pertaining to you.

Right to be Notified of a Breach of Unsecured PHI (Protected Health Information)

Right to Opt Out of Fundraising Requests: You have the right to notify us if you would prefer not to receive fundraising requests.

Right to Restrict for Out-of-Pocket Care: You have the right to restrict information from being sent to or accessed by Medicare or your private insurance health plan if you pay your bill out of pocket and in full for services rendered. This rule does not apply to Medicaid patients.

Right to Paper Copy of this Notice: You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice. You may also obtain a copy of this notice at our website: www.cornellscott.org.

Changes to this Notice: We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. Our notice will indicate the effective date on the last page. We will also give you a copy of our current notice upon request. Any revised notice may also be obtained by visiting our website: www.cornellscott.org.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Service for Civil Rights by sending a letter

200 Independence Avenue, S.W., Washington, D.C. 20201 or by calling 1-877-696-6775 or by visiting

www.hhs.gov/ocr/privacy/hipaa/complaints/.

You may file a complaint by mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

Director of Health Information/Privacy Officer: 203-503-3153

Cornell Scott-Hill Health Center • 400 Columbus Ave, New Haven, CT 06519

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care we provided to you.

Cornell Scott-Hill Health Center (CS-HHC) continually strives to provide the highest possible standard of care. To help us in our efforts to continually improve our services, we invite you to report to the CS-HHC administration concerns about the quality of care you have received or the safety and cleanliness of our facilities. To contact us by phone call **203-503-3153**.

Because we are accredited by the Joint Commission, a national accreditation agency, you may contact them in writing at:

One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181 or by phone at **(630) 792-5000**.



Registration Form

As a community health center, it's important for us to know the population we're serving to provide the best care possible. Please answer these questions so that we may provide you with the highest quality of care and offer appropriate services and programs.

All information is confidential

Which Category or Categories Best Describe Your Race?

- Black/African American
- Filipino
- Japanese
- Guamanian or Chamorro
- Korean
- Pacific Islander
- American Indian/Alaska Native
- Middle Eastern or Northern African
- Samoan
- White
- More than one race
- Asian
- Asian Indian
- Native Hawaiian
- Chinese
- Vietnamese
- Prefer not to answer

Choose Ethnic Background: **See Reverse**

Ethnicity: Hispanic or Latina/o/x Not Hispanic or Latino Cuban Puerto Rican
 Mexican, Mexican American, Chicano/a prefer not to answer I don't know

Do you speak English? Yes No

Do you read in English? Yes No

Preferred Language: _____

Do you write in English? Yes No

Residence:

- Private Residence
- Public Housing
- Section 8 Housing
- Nursing Home
- Group Home
- Homeless
- Shelter
- Street
- Doubling Up
- Transitional
- Temporary Housing

Are you a veteran? Yes No

Are you a farm worker or migrant worker? Farm Worker Migrant Worker Neither

Sexual Orientation

- Straight (not lesbian or gay)
- Lesbian or Gay
- Bisexual
- Something else
- Don't know
- Choose not to disclose

Gender Identity

- Male
- Female
- Transgender Male/Female-to-Male
- Transgender Female/Male-to-Female
- Other
- Gender non-conforming
- Genderqueer
- Intersex
- Choose not to disclose
- Transsexual

Family Size **(Please choose category on back):** _____ **Monthly income:** A/B/C/D/E

MR# _____

Family Size	Category A 0-100%	Category B >100%-125%	Category C >125%-150%	Category D >150%-175%	Category E >175%-200%
1 person	\$0-\$14,580	\$14,581-\$18,225	\$18,226-\$21,870	\$21,871-\$25,515	\$25,516-\$29,160
2 people	\$0-\$19,720	\$19,721-\$24,650	\$24,651-\$29,580	\$29,581-\$34,510	\$34,511-\$39,440
3 people	\$0-\$24,860	\$24,861-\$31,075	\$31,076-\$37,290	\$37,291-\$43,505	\$43,506-\$49,720
4 people	\$0-\$30,000	\$30,001-\$37,500	\$37,501-\$45,000	\$45,001-\$52,500	\$52,501-\$60,000
5 people	\$0-\$35,140	\$35,141-\$43,925	\$43,926-\$52,710	\$52,711-\$61,495	\$61,496-\$70,280
6 people	\$0-\$40,280	\$40,281-\$50,350	\$50,351-\$60,420	\$60,421-\$70,490	\$70,491-\$80,560
7 people	\$0-\$45,420	\$45,421-\$56,775	\$56,776-\$68,130	\$68,131-\$79,485	\$79,486-\$90,840
8 people	\$0-\$50,560	\$50,561-\$63,200	\$63,201-\$75,840	\$75,841-\$88,480	\$88,481-\$101,120
Each additional person add	\$5,140	\$6,425	\$7,710	\$8,995	\$10,280

Please circle ethnic background:

African
African American
Alaska Native
American Indian or Alaska Native Not Listed Here
Arab
Argentinian
Asian Indian
Asian Not Listed Here
Bangladeshi
Black or African American Not Listed Here
Burmese
Cambodian
Cherokee
Chilean
Chinese
Columbian
Cuban
Dominican/Black
Dominican/Hispanic
Ecuadorian
Ethnic Background Not Listed
European
Filipino
Guatemalan
Guatemalan or Chamorro
Haitian
Hispanic or Latina/o/x Ethnicity or Spanish Origin Not Listed Here
Hmong
Honduran
I Do Not Know
Indonesian
Iroquois
Jamaican

Japanese
Korean
Laotian
Malaysian
Mashantucket Pequot
Mexican, Mexican American, Chicano/a
Middle Eastern or Northern African
Mohegan
Native Hawaiian
Nepalese
Nicaraguan
Pacific Islander Not Listed Here
Pakistani
Panamanian
Peruvian
Portuguese
Prefer Not To Share
Puerto Rican
Salvadorian
Samoan
Spaniard
Spanish
Sri Lankan
Taiwanese
Thai
Uruguayan
Venezuelan
Vietnamese
West Indian
White Not Listed HereHere



Parent Permission Form for Dental Services

Dear Parent/Guardian,

We are pleased to announce we are now offering dental services to students in your child’s school.

A dentist will provide these services during school hours:

- Dental examinations /school wide screenings
- Sealants
- Oral health instruction & education
- Prophylaxis (cleanings)
- Radiographs (x-rays)
- Referrals made for other services (fillings, extractions)
- Fluoride treatments
- Assessment and referrals for walk-in conditions

Please fill out the following information and return this form to your child’s school health center, if you would like your child to be eligible for these services. We will bill your insurance company as we do for any SHC service at no cost to you.

Please fill out one form per child.

PERSONAL, MEDICAL AND BILLING INFORMATION	
Child's Full Name	
Date of Birth:	
Child's HUSKY/Medicaid#:	
Telephone:	
Does your child have a regular dentist?	YES <input type="checkbox"/> NO <input type="checkbox"/>
If yes, dentist's name and phone #:	
List any medications your child takes:	
Allergies	YES <input type="checkbox"/> NO <input type="checkbox"/>
Heart Condition or Heart Murmur	YES <input type="checkbox"/> NO <input type="checkbox"/>
Seizures	YES <input type="checkbox"/> NO <input type="checkbox"/>
Problems with bleeding	YES <input type="checkbox"/> NO <input type="checkbox"/>
Any other medical problem not listed	YES <input type="checkbox"/> NO <input type="checkbox"/>
Please describe any yes answers above:	
Parent/Guardian's Full Name:	
Other Dental Insurance:	
Name of Insured:	
Policy #:	

IF you DO NOT want your child to receive any of the services listed above, please list them here:

PERMISSION FOR TREATMENT

You have my permission to perform any necessary dental treatment on the top of this form. I will be notified if my child needs additional dental treatment not available at my child’s school. I give permission for the dentist to use local anesthesia if it is needed to numb the tooth. I also give permission to release information regarding treatment and/or services to insurance providers for the purpose of billing and authorize payments be made directly to CSHHC.

SIGNATURE: _____ DATE: _____

PRINT NAME: _____ RELATIONSHIP TO CHILD: _____