



**FRANKLIN
PRIMARY**
HEALTH CENTER INC

School-Based Health Center Consent & Enrollment Form

Chickasaw City Schools | Type directly into the shaded fields, save, then sign and return to your school nurse.

Child Information

Child Name: Child SS#:
For privacy, write the SS# by hand after printing.

Date of Birth: Gender: Grade:

Race (black, white, etc.):

Ethnicity (Non-Hispanic, Mexican, etc.):

Language: Phone #:

Homeless Status (select one):

☐ Not Homeless ☐ Homeless ☐ Living in Shelter
☐ Living with Others ☐ At Risk of Homeless ☐ Other

If other, explain:

Address: City:

State: Zip: Email Address:

Parent/Guardian Information

Name: Relationship to Child:

Phone #: Alternate #:

Email Address:

Emergency Contact Information

Name: Relationship to Child:

Phone #: Alternate #:

Child's Insurance Information

Primary Health Insurance

Name of insured parent/guardian:

Address (if different from child):

Date of birth of insured cardholder: Place of employment:

Name of insurance company: Phone/fax:

Group & ID number:

Secondary Health Insurance

Name of insured parent/guardian:

Address (if different from child):

Date of birth of insured cardholder: Place of employment:

Name of insurance company: Phone/fax:

Group & ID number:

Person responsible for bill: DOB:

If no insurance, household size: Annual income:

(Household size and income are needed for the sliding fee scale discount.)

Health Information

1. Does your child currently have or have a history of the following problems? (check all that apply)

- | | | |
|---|--|---|
| ☐ Allergies | ☐ Asthma | ☐ Birth problems |
| ☐ Blood clots/strokes | ☐ Cancer | ☐ Chicken pox |
| ☐ Developmental delays | ☐ Diabetes | ☐ Headaches |
| ☐ Heart disease | ☐ High blood pressure | ☐ High cholesterol |
| ☐ Mental illness | ☐ Seizures | ☐ Sickle cell anemia |
| ☐ Substance abuse | ☐ Tuberculosis | ☐ Other |

Allergies (food, medications, other) - explain:

Mental illness - explain:

Substance abuse - explain:

Other - explain:

2. Has your child had any minor or major surgeries? If yes, please explain.

3. Has your child been hospitalized for anything? If yes, please explain.

4. Does your child take any medications? If yes, please list.

5. Pediatrician name/phone number:

6. Date of last well child visit:

7. Dentist name/phone number:

8. Last dental exam:
9. Optometrist name/phone number:
10. Date of last eye exam:
11. Pharmacy your child uses (name and phone number):

Family History

Does anyone in your family (mother, father, siblings, and grandparents) currently have or have a history of the following problems?

Condition	Who?	Maternal or Paternal side?
Asthma		
Blood clots/stroke		
Diabetes		
Heart disease		
High blood pressure		
High cholesterol		
Mental illness		
Sickle cell anemia		
Substance abuse		
Tuberculosis		
Other		

Consent

I give consent for the child named above, to receive services from the Franklin Primary Health Center School Based Health Center. Services may include the following: well-child physicals, sport physicals, diagnosis and treatment for acute and chronic conditions, vision, dental, minor injuries, immunizations, health coaching, prescriptions, behavioral/mental health counseling, classroom presentations (as assigned), and referral for services which cannot be provided at FPHC SBHC.

Franklin's patient rights and responsibilities, notice of privacy practices and grievance policies have been explained to me and I have received a copy. I have also been informed that if I have a complaint or experience any problems during my visit to ask for the office manager.

Initials:

Assignment and release: I, the undersigned certify that the above information is true and correct. I consent to any services rendered to my child under doctor's orders. I authorize payment of healthcare benefits to FPHC, Inc. I understand that I am financially responsible for all charges and reference lab fees not paid by insurance. I hereby authorize FPHC, Inc., to release all information necessary to secure payment of benefits.

I understand that this consent form will be valid until my child leaves/graduates from FPHC SBHC. I may revoke this consent form at any time.

I have read the above information and have had the opportunity to have any of my questions answered.

Signature of Parent/Legal Guardian:

Date:

Sign by typing your full name, or print the completed form and sign by hand. Return the signed form to your child's school nurse. Do not email this form - it contains private health and insurance information.