



SCHOOL-BASED HEALTH CENTERS
ENROLLMENT FORM

2007 - 2008

Mannsville Elementary: 315-465-3373
North Elementary: 315-786-1767 Harold T. Wiley: 315-785-3783

1. STUDENT'S NAME (Last) (First) (Middle Initial) DATE:

2. SCHOOL 3. GRADE TEACHER 4. SEX M F

5. BIRTHDATE / / 6. RACE: Asian Black White Hispanic Native American Other

7. PLEASE CHECK BELOW WHICH BEST FITS YOUR NEEDS:

My child does not have a regular doctor or clinic and we would like to use the Children's Clinic School-Based Health Center and Primary Care Center (located at 238 Arsenal St.) for health care.

My child goes to the North Country Children's Clinic. We are usually seen at (circle one): Arsenal St. School Both

My child regularly goes to another doctor: Name of doctor

Last seen on. Last physical exam on. I would like to use the School-Based Health Center when necessary. I give permission for the Health Center to obtain copies of my/my child's immunization record and physical exams from my doctor or clinic. I understand that my doctor will receive a report following each visit to the Health Center.

Parent/Guardian Signature date

All students who use the school based health centers are required by New York State to have a comprehensive physical exam upon enrollment and then every other year. When an exam is due (please check one below):

I would like The Children's Clinic School Health Center to schedule a physical exam. I will provide a copy of one.

8. PARENT OR GUARDIAN INFORMATION (Please fill out completely)

NAME (FIRST) (LAST)

NAME (FIRST) (LAST)

ADDRESS (STREET)

ADDRESS (STREET)

(CITY) (STATE) (ZIP CODE)

(CITY) (STATE) (ZIP CODE)

SS # - - BIRTHDAY / /

SS # - - BIRTHDAY / /

EMPLOYER

EMPLOYER

PHONE: (H) (W) (cell)

PHONE: (H) (W) (cell)

E-MAIL

E-MAIL

LIVING AT HOME? YES NO HEALTH STATUS

LIVING AT HOME? YES NO HEALTH STATUS

RELATIONSHIP TO STUDENT

RELATIONSHIP TO STUDENT

9. IF PARENT/GUARDIAN NOT AVAILABLE, PLEASE CONTACT: PHONE

10. NUMBER OF PEOPLE IN HOUSEHOLD SIBLINGS: (NAMES & AGES)

11. ANNUAL GROSS INCOME: \$10,000 - \$20,000 \$20,000 - \$30,000 \$30,000 - \$40,000 \$40,000 & OVER

12. IS STUDENT COVERED BY MEDICAID? YES NO IF YES, MEDICAID # / / / / / / / / / / SEQ # / /

13. IS STUDENT COVERED BY HEALTH INSURANCE? YES NO

INSURANCE NAME POLICY ID#

ADDRESS (STREET) (CITY) (STATE) (ZIP CODE) PHONE ()

POLICY HOLDER (FIRST) (LAST) GROUP CODE

14. IS INSURANCE AN HMO? YES NO CHILD HEALTH PLUS? YES NO TRICARE? YES NO MARTINS POINT? YES NO If any answer is YES, and your child's primary care physician is not with the Children's Clinic, or you have Tricare Prime, we advise that you use that physician/clinic. If you think you may need our health services in an emergency, please complete this form.

STUDENT'S PRIMARY CARE PHYSICIAN

Medical History - North Country Children's Clinic

Student's Name _____ Date of Birth _____ Sex _____

Current Health Status _____ Allergies (including Latex) _____

Medications Taken (names and dosages) _____

FAMILY DRUG STORE _____ LOCATION _____

Hospitalizations _____
Dates _____ Where _____ Reasons _____

Past History (Please give the dates for all that your child has had)

Chicken Pox _____ Ear infections _____ Urinary tract infections _____

Tonsillitis _____ Pneumonia _____ Other _____

Chronic Health Problems (Please give age when began) Diabetes _____ Asthma _____ Seizure Disorder _____

Sickle Cell Status _____ Cancer _____ Developmental Delay _____ Explain _____

Emotional /Behavioral Concerns _____

If so, would you like your child to see a counselor? ___yes___no. If yes, please contact the clinic for an appointment.

Does Your Child See a Specialist? Name(s) and purpose of visit _____

Family History (Circle any of the following if mom, dad, sisters, brothers, aunts, uncles, grandparents have had. Include both sides of the family) allergies asthma high blood pressure stroke high cholesterol diabetes hepatitis seizure disorder cancer HIV positive migraine TB mental disorder stomach/GI problems history unknown

Are there any smokers in your house? ___yes___no

Has your child or a close household contact ever:

had a positive Tb screen?	___yes___no	taken IV street drugs?	___yes___no
been infected with tuberculosis of a lung	___yes___no	been diagnosed with a serious disease?	___yes___no
or is taking care of a TB patient?	___yes___no	(cancer/diabetes/kidney disease/HIV +)	___yes___no
from Latin America, SE Asia, Africa,	___yes___no	taken medicine called corticosteroids?	___yes___no
the Caribbean, Eastern Europe, or is	___yes___no	have concerns about lead problems	___yes___no
a Native American?	___yes___no	with your child?	___yes___no
been in prison or a homeless shelter or	___yes___no		
been a migrant worker?	___yes___no		

PARENTAL REQUEST FOR HEALTH SERVICES

I give my consent for my child, _____ to receive services provided by the staff of the The Children's Clinic at the Health Center and Dental Clinic and for my child, if necessary, to be transported to a site by a certified driver. Also, I give my consent for the staff to have access to my child's school health records. I give my permission for the release of my child's records to his/her physician and the appropriate information from the physical exam to the school nurse. I authorize insurance and/or Medicaid payments for services rendered for my dependents directly to **North Country Children's Clinic, Inc.** and the release of medical information necessary to process all claims to my insurance carrier.

Services may include the following:

- | | |
|--|---|
| Comprehensive physical examinations | Care for skin problems |
| Treatment of illness and injury | Counseling for school and personal problems |
| Monitoring of chronic illness and disabling conditions | Referrals to agencies for services not provided at the Center |
| Prescriptions, immunizations and lab work | Dental services will be provided by referral only |
| Nutrition and weight counseling | Hemoglobin, Lead and TB testing |

I understand that every effort will be made to contact me prior to treatment. The staff of the Children's Clinic believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in health care decisions. We encourage parents to visit or call the Health Center at any time.

Signature of parent/guardian _____ Date _____ Reviewed by _____
Form#SBC101