



North Country Children's Clinic School Based Health Centers Date: _____

ENROLLMENT FORM

Case Middle School: 785-3809 Watertown High School: 785-3703 DATE _____

1. STUDENT'S NAME _____ 2. GRADE _____ 3. SEX: M F

4. BIRTHDATE ____/____/____ 5. STUDENT'S SOCIAL SECURITY # _____ - _____ - _____ 6. RACE Asian Black White

Native American Other Hispanic

7. PLEASE CHECK BELOW WHICH BEST FITS YOUR NEEDS

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

My child regularly goes to another doctor or clinic for health care and I would like to use the North Country Children's Clinic School Based Health Center when necessary. I understand that my child's doctor will receive reports following visits.

Name of doctor/clinic _____ Last seen _____ Last physical exam _____

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

8. 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 year. When an exam is due (please check one below):

I would like the School Health Center to schedule a physical exam. I will provide a copy of one.

9. PARENT OR GUARDIAN INFORMATION (Please fill out completely) NUMBER OF PERSONS IN HOUSEHOLD: _____

NAME _____ (First) (Last)

NAME _____ (First) (Last)

ADDRESS _____ (Street)

ADDRESS _____ (if different) (Street)

(City) (State) (Zip Code)

(City) (State) (Zip Code)

SS # _____ - _____ - _____ BIRTHDAY ____/____/____

SS # _____ - _____ - _____ BIRTHDAY ____/____/____

EMPLOYER _____

EMPLOYER _____

HOME PH _____ WORK PH _____

HOME PH _____ WORK PH _____

CELL PH _____ E-MAIL _____

CELL PH _____ E-MAIL _____

10. APPROXIMATE ANNUAL GROSS INCOME (check one):

UNDER 10,000 10,000 - 20,000 20,000 - 30,000 OVER 30,000

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

12. IS STUDENT COVERED BY HEALTH INSURANCE? YES NO

INSURANCE NAME _____ POLICY ID# _____

ADDRESS _____ (Street) (City) (State) (Zip Code) PHONE (____) _____

POLICY HOLDERS NAME _____ (First) (Last) GROUP # _____

13. IS INSURANCE AN HMO? YES NO CHILD HEALTH PLUS? YES NO TRICARE? _____ PRIME _____ STANDARD

If either 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. Of course, in an emergency, we will see any enrolled student with a parent's permission.

STUDENT'S PRIMARY CARE PHYSICIAN: _____

FAMILY DRUG STORE: _____

Medical History - North Country Children's Clinic

STUDENT'S NAME _____ DATE OF BIRTH _____

current health status _____ allergies (including latex) _____

medications taken (names and dosages) _____

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/Frequent illnesses _____

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

Sickle Cell Status _____ Cancer _____ Developmental Delay _____ Other _____

Emotional /Behavioral Concerns _____

If yes, would you like your child to see a counselor? _____ If so, the clinic will contact you.

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

obesity Are there any smokers in your house? ___yes___no

TUBERCULOSIS SCREENING; has your child or a close household contact ever:

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

Any developmental delays or problems? Please explain: _____

PARENTAL REQUEST FOR HEALTH SERVICES

I give my consent for my child, _____ to receive services provided by the staff of the North Country Children's Clinic at the Health Center and Dental Clinic. Also, I give my consent for the NCCC 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 Clinic
Prescriptions and immunizations	Dental services will be provided by referral only
Nutrition and weight counseling	

I understand that every effort will be made to contact me prior to treatment. The staff of the North Country 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.

Date _____

Signature of parent/guardian
form#SBC102