Client ID: _____

Staff Initials: _____

UCFS School Based Health Center
Enrollment Form

UCFS Healthcare
SCHOOL-BASED HEALTH CENTERS

☐ Kelly STEAM Magnet Middle School, 25 Mahan Drive, Norwich, CT
860-934-1101

☐ John B. Stanton Elementary School, 386 New London Turnpike, Norwich, CT
860-934-1107

☐ Teacher's Memorial Global Studies Magnet Middle School, 15 Teachers Drive, Norwich, CT
860-934-1150

☐ Norwich Technical High School, 7 Mahan Drive, Norwich, CT
860-822-4909

☐ Norwich Free Academy, 305 Broadway, Norwich, CT
860-425-5557

☐ Montville High School, 800 Old Colchester Road, Oakdale, CT
860-822-4914

The UCFS School Based Health Centers offer the following services:

Behavioral Health – Mental Health Assessments, Substance Abuse Screenings, Counseling (individual, group and family)
Medical - Physicals, Preventive Care, Immunizations, Treatment of Minor Injuries and Illness, Reproductive Health and Health Education
Dental Health – Dental Hygiene Cleanings, Preventive Care (specific times of the year by appointment only)

Who Can Receive Services? Only students who are enrolled in school where there is a School Based Health Center can receive services. It is not open to the public.

Why Enroll Your Child? Students receive the care they need on premises during the school day without missing class. Parents do not need to miss work to take their child to appointments. UCFS School Based Health Center collaborates and communicates with your child's primary care provider.

How Do I Enroll My Child? To enroll your child in school based services, please complete all attached forms in pen and return to the School's Main Office. Additional forms can be found at UCFShealthcare.org. By enrolling in a UCFS School Based Health Center your child is able to receive services at any UCFS School Based Health Center located in the school your child is enrolled in.

Cost: Insurance is billed whenever possible in order to sustain the UCFS School Based Health Center. However, students will receive care regardless of the ability to pay. Co-pays will be billed directly to the parent/guardian.

Student Information:

Student Name: _____ Date of Birth: _____ Grade: _____

Address:_____Town:_____

State:_____ Zip:_____Social Security Number:_____

Phone (Check Primary Number) ☐Cell:_____ ☐ Home:_____ ☐Work:_____

Preferred Pharmacy: _____ Pharmacy Town:_____

Email Address:_____

Do you give consent to UCFS to obtain your health history (circle one): **YES** **NO**
UCFS may leave a message with results on: **Home** ☐ **Cell** ☐ **None** ☐

Is the student now, or have they ever been a UCFS Patient? **YES** **NO**
If yes, circle all that apply: ☐ **Medical** ☐ **Dental** ☐ **Behavioral Health**

Student's Primary Care Provider Name:	**Phone Number:**
Student's Dental Provider Name:	**Phone Number:**
Student's Behavioral Health Provider Name:	**Phone Number:**

Where else does your child receive services? ☐**Emergency Room** ☐**Walk in/Urgent Care Clinic** ☐**Military Clinic**

Preferred Language:_____
Hispanic/Latino (circle one): **YES** **NO**

☐ Asian ☐ American Indian or Alaskan Native
☐ Black or African American ☐ White ☐ Native Hawaiian
☐ Other Pacific Islander Other Please Specify:_____

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SCHOOL-BASED HEALTH CENTERS

Sexual Orientation: ☐ Straight heterosexual ☐ Lesbian, gay or homosexual ☐ Bisexual
☐ Something Else ☐ Don't Know ☐ Choose not to disclose

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Female-to Male ☐ Transgender Female/Male-to-Female
☐ Gender Queer ☐ Other ☐ Choose not to disclose

Associated Parties (Please indicate anyone, other than parents, whom UCFS may speak to regarding the following: Please initial all that apply.)

Name And Address	DOB	Relationship to client	Phone Number	Emergency Contact	Discuss Appointment Information	If Client is a minor May Bring to Appointments

Responsible Party (Please use if Minor under 18 for Parent, Guardian, DCF, POA)

Name:	Relationship to Client:	DOB: / /
Address:	Primary Phone#:	
City/State/Zip code:	Secondary Phone#:	
Name:	Relationship to Client:	DOB: / /
Address:	Primary Phone#:	
City/State/Zip code:	Secondary Phone#:	

How many people are in your household?_____
Have you been homeless any day during the last 12 months (circle one)? **YES** **NO**
When?_____

What is your estimated household income per year?
☐ $0-$9,999 ☐ $10,000-$19,999 ☐ $20,000-29,999
☐ $30,000-$39,000 ☐ $40,000-$49,000 ☐ $50,000+

I/We (Print Name)_____; (Print Name) _____ hereby state that I/we are the legal parent(s) of the child indicated below and I/we have the authority to make decisions on all medical and treatment services. I/we hereby request and give permission to United Community & Family Service, Inc., to treat my/our child who is listed below.

Child's Name (Print name) _____ Child's D.O.B. _____

If an alternative legal Parent/Guardian is not present upon completion of this document, please indicate the individual who also has the authority to make medical and treatment decisions on the child's behalf.

Name of legal Parent/Guardian not present; (Print name) _____

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UCFS Healthcare
SCHOOL-BASED HEALTH CENTERS

Insurance Information:

Primary Medical/Behavioral Health Insurance Plan:_____

Policy Holder First Name:_____ Last Name:_____ Middle Initial:_____

Policy Holder DOB:_____ Policy Holder SS#:_____ Employer:_____

Group Number:_____Policy Number:_____

Secondary Medical/Behavioral Health Insurance Plan:_____

Policy Holder First Name:_____ Last Name:_____ Middle Initial:_____

Policy Holder DOB:_____ Policy Holder SS#:_____ Employer:_____

Group Number:_____Policy Number:_____

Dental Insurance Plan:_____

Policy Holder First Name:_____ Last Name:_____ Middle Initial:_____

Policy Holder DOB:_____ Policy Holder SS#:_____ Employer:_____

Group Number:_____Policy Number:_____

Would you like someone to contact you about applying to (circle one): **Insurance (Husky)** **SNAP (Food Stamps)**

Payment Information:

Who is responsible for payment of services provided ☐ Self ☐ Other (Please complete blow)	
Relationship:	
Name:	Birthdate:
Address:	Social Security #:
City/State/Zip code:	Employer Name:
Home Phone #:	Cell Phone #:

By signing below, I authorize UCFS to communicate with the Associated Parties listed above regarding routine appointment information and/or, if client is a minor, I authorize such person(s) to bring my child in for routine appointments

I understand that it is my responsibility to update UCFS with changes to the Associate Parties listed above. What I have provided above will remain active and in effect until such time new information is provided to UCFS.

☐ **By checking this box, I am acknowledging that I have been offered/received the UCFS Patient Handbook**

Printed Name:_____ **Date:**_____

Signature of client patient or legal guardian:_____

Client ID: _____

Staff Initials: _____

UCFS School Based Health Center
Enrollment Form

UCFS Healthcare
SCHOOL-BASED HEALTH CENTERS

Student Health History

Student Name:_____ Date of Birth:_____

Does your child have any of the following conditions?									
ADD/ADHD	☐	Yes	☐	No	Heart Disease/Problems	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Hypertension	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Immune Disorder	☐	Yes	☐	No
Birth Defects	☐	Yes	☐	No	Learning Difficulties/Developmental Delays	☐	Yes	☐	No
Bipolar	☐	Yes	☐	No	Mental Illness	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Overweight	☐	Yes	☐	No
Diabetes	☐	Yes	☐	No	Seizures	☐	Yes	☐	No
Dental Problems	☐	Yes	☐	No	Sleeping Problems – At what age did your child sleep through the night? _____	☐	Yes	☐	No
Depression	☐	Yes	☐	No	Substance Abuse (alcohol or drugs)	☐	Yes	☐	No
Eczema	☐	Yes	☐	No	Tobacco Use	☐	Yes	☐	No
HIV/AIDS	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐	No
Head Injury	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐	No
Hearing Problems	☐	Yes	☐	No	Weight Loss	☐	Yes	☐	No
High Blood Pressure	☐	Yes	☐	No	Other Conditions/Concerns:				

Has your child been in the hospital overnight?	☐	Yes	☐	No	When:	Why:
Has your child had surgery?	☐	Yes	☐	No	When:	Why:
Has your child been in a serious accident?	☐	Yes	☐	No	When:	Why:
Does your child take any medicines?	☐	Yes	☐	No	Name of Medicine:	
Does your child take any vitamins or supplements?	☐	Yes	☐	No	Please list:	
Is your child allergic to any medicine?	☐	Yes	☐	No	Name of medicine:	
Is your child allergic to food or other things?	☐	Yes	☐	No	Name of food/other:	
Has your child had chicken pox?	☐	Yes	☐	No	At what age?	
Is your child receiving any counseling at this time?	☐	Yes	☐	No	Where?	
Has your child been in counseling in the past?	☐	Yes	☐	No	Where?	

If female, is the student:				
Pregnant or possibly pregnant?	☐	Yes	☐	No
Having Menstrual Problems?	☐	Yes	☐	No

For dental services, does the student:									
Have special mobility needs?	☐	Yes	☐	No	Have any needs the hygienist should know before treating the student?	☐	Yes	☐	No
Have experience seeing a dentist?	☐	Yes	☐	No	Have gums that bleed while brushing or flossing?	☐	Yes	☐	No
Require pre-medication before dental treatment?	☐	Yes	☐	No	Have teeth causing him/her pain?	☐	Yes	☐	No

FAMILY HISTORY: Does anyone in the child's family have the following conditions? (Mother, Father, Sibling, Grandparent)

					Family Member					Family Member
ADD/ADHD	☐	Yes	☐	No		Heart Disease	☐	Yes	☐	No	
Anemia	☐	Yes	☐	No		Hypertension	☐	Yes	☐	No	
Asthma	☐	Yes	☐	No		Immune Disorder	☐	Yes	☐	No	
Birth Defects	☐	Yes	☐	No		Learning Difficulties	☐	Yes	☐	No	
Bipolar	☐	Yes	☐	No		Overweight	☐	Yes	☐	No	
Cancer	☐	Yes	☐	No		Seizures	☐	Yes	☐	No	
Diabetes	☐	Yes	☐	No		Substance Abuse	☐	Yes	☐	No	
Dental Problems	☐	Yes	☐	No		Tobacco Use	☐	Yes	☐	No	
Depression	☐	Yes	☐	No		Thyroid Disease	☐	Yes	☐	No	
Eczema	☐	Yes	☐	No		Tuberculosis	☐	Yes	☐	No	
Head Injury	☐	Yes	☐	No		Menstrual Problems	☐	Yes	☐	No	

Client ID: _____

Staff Initials: _____

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UCFS Healthcare
SCHOOL-BASED HEALTH CENTERS

Consent for Services:

Student Name:_____ Date of Birth:_____

Consent: By signing below, I understand and acknowledge I have read and understand this consent.

I give permission for my child to receive the following services at the UCFS School Based Health Center. I certify that the health information provided is accurate to the best of knowledge. I understand that providing incorrect information may be dangerous to the student's/patient's health. I will contact school based staff if my child's health history changes.

Medical Services

- Teenagers may avoid getting needed care for certain problems unless they know that they can be treated confidentially and parents most often would prefer that their children have a place to turn when they need medical care. Adolescents, while encouraged to communicate with their parents, can receive confidential services for Sexually Transmitted Disease Testing and Treatment, Pregnancy Testing, Family Planning Counseling and Referral and Substance Abuse Counseling and Referral. I understand my adolescent may choose to receive confidential services. I understand that information regarding the above conditions will be shared if the adolescent agrees or when there is a serious health risk that requires reporting by State or Federal law.

Smiles on the Move Mobile Dental

☐ Check here if you would like to be contacted by Smiles on the Move.

Release of Information and Payment Authorization

- I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to UCFS for services provided.

Authorization for Exchange of Health and Education Information:

- I hereby authorize UCFS to exchange health and education records with my child's school district for the purpose of providing treatment to my child.

Consent and Acknowledgement of Privacy Practices:

- I consent to the use of disclosure of my protected health information by UCFS to any person or organization or the purposes of carrying out treatment, obtaining payment, or conducting certain health care operations. Protected health information used or disclosed by UCFS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how UCFS will use and disclose my information can be founded in UCFS' Notice of Privacy Practices. I understand that this consent is effective for as long as UCFS maintains my protected health information.
- I acknowledge that I have received the UCFS Patient Rights and Responsibility Policy.
- I understand my child will continue to be enrolled in the UCFS School Based Health Center, as long as, the child is enrolled in a school with a UCFS School Based Health Center.
- Annually demographic information will be updated and at any time I have the right to opt out of the School Based Health Center at UCFS by emailing sbhc@ucfs.org.

_____ _____

Printed Name **Relationship**

_____ _____

Signature of client, parent, legal guardian
Personal representative **Date**