Medical History – please fill out completely

Child & Family Agency of Southeastern Connecticut, Inc. It's About Children

Patient (Student) Full name:

MEDICAL HISTORY			Date of Last Physical Exam: ____/____/____
Does the patient have any medical conditions?	☐YES	☐NO	Explain:
Does the patient take any medications (including inhalers or vitamins)?	☐YES	☐NO	List:
Has the patient had any serious injuries (including a head injury)?	☐YES	☐NO	Explain:
Does the patient have a birth or heart defect?	☐YES	☐NO	Explain:
Has the patient ever been hospitalized overnight?	☐YES	☐NO	Explain:
Has the patient had any surgery in the past?	☐YES	☐NO	Explain:
Does the patient have any problems with sleeping and/or snoring?	☐YES	☐NO	Explain:
Has the patient had a dental cleaning within the past 6 months?	☐YES	☐NO	
Does anyone smoke in the home?	☐YES	☐NO	
Does the patient smoke, use e- cigarettes, or chew tobacco?	☐YES	☐NO	
Does the patient get 60 min of exercise at least 3 times a week?	☐YES	☐NO	
Are you concerned with the amount of time your child spends on social media, T.V., video games, computer, or phone?	☐YES	☐NO	Explain:
Any other concerns about your child's health or weight?	☐YES	☐NO	Explain:

Does the patient have or had any of these PROBLEMS?					
Anemia/Blood Disorders	☐YES	☐NO	Pneumonia	☐YES	☐NO
Asthma	☐YES	☐NO	Rheumatic Fever or Heart Disease	☐YES	☐NO
Autism	☐YES	☐NO	Heart Murmur	☐YES	☐NO
Bladder or Kidney Infections	☐YES	☐NO	Scoliosis	☐YES	☐NO
Cancer/Leukemia	☐YES	☐NO	Seizures	☐YES	☐NO
Chicken Pox	☐YES	☐NO	Skin Problem (Eczema, Acne, etc.)	☐YES	☐NO
Diabetes	☐YES	☐NO	Thyroid Disease	☐YES	☐NO
Eating Issues	☐YES	☐NO	Tuberculosis	☐YES	☐NO
Endocrine/Gland Disease/Autoimmune Disease	☐YES	☐NO	Ulcer/Digestive Issues	☐YES	☐NO
Headaches/Migraines	☐YES	☐NO	Mental Health Issues	☐YES	☐NO
Hepatitis or Liver Problems	☐YES	☐NO	Birth Defects (Spina Bifida, Heart, Lung, Brain, etc.)	☐YES	☐NO
Learning/Developmental Issues	☐YES	☐NO	Problems with Teeth or Gums	☐YES	☐NO
Seasonal Allergies	☐YES	☐NO	Other:		
Overweight or Obesity	☐YES	☐NO			
FAMILY HISTORY of any of the above:					

ALLERGIES			
Any foods? (including lactose intolerance)	☐YES	☐NO	Comment:
Any medications? (including over the counter or antibiotics)	☐YES	☐NO	Comment:
Does the patient have an Epi-Pen (or similar prescription) at school?	☐YES	☐NO	Comment:
Other:			

BEHAVIORAL HEALTH

Has the patient ever had or currently receiving counseling services? ☐YES ☐NO If yes, when/with whom?

Are you interested in your child receiving mental health counseling at the SBHC? ☐YES ☐NO

Has the patient ever had any of the following:

Family changes	☐YES	☐NO	Anger issues	☐YES	☐NO
School issues	☐YES	☐NO	Attention difficulties	☐YES	☐NO
Social/peer stresses	☐YES	☐NO	Sadness and/or mood swings	☐YES	☐NO
Anxiety	☐YES	☐NO	Truancy/school avoidance	☐YES	☐NO
Learning disabilities	☐YES	☐NO	Recent loss/crisis	☐YES	☐NO

If answered yes to any of the above, please comment:

School-Based Health Center Enrollment Form

Please fill out (2 sides) and call 860-437-4555 with any questions.

STUDENT INFORMATION

Full Legal Name: *(of person who will receive services)* ______________________________ DOB: __________

Street Address/Apt. #: ______________________________ City: ______________ Zip: __________

Sex: Male Female Ethnicity (check box): Hispanic Non-Hispanic Student's Primary Language: __________

Race (check box): Unknown American Indian Pacific Island Alaskan Native Black Asian White Other

Does the student qualify for free/reduced lunch? YES NO School Student Attends: ______________ Grade: ______

Primary Care Provider's Name: ______________________________ Phone Number: __________

Dentist's Name: ______________________________ Phone Number: __________

INSURANCE INFORMATION

No Insurance

Medical Insurance(s): ______________________ Medicaid ID# ______________

Insurance Address: ______________________ Insurance Phone # (on back of card) ______________

Policy Holder Name: ______________________ Policy Holder DOB: ______________

Private Insurance ID/Policy #: ______________________ Group Number: ______________

Insurance Address: ______________________ Insurance Phone # (on back of card) ______________

Policy Holder Name: ______________________ Policy Holder DOB: ______________

PARENT/GUARDIAN INFORMATION

Name: ______________________ Relationship to Student: ______________ DOB: __________

Street Address/Apt. # (if different from above): ______________________ City: ______________ ZIP: __________

I agree that voicemail messages can be left for me on: Home Phone Cell Phone Work Phone

Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________

Parent/Guardian Email Address: ______________________________

Student's Cell Phone: ______________ Student's Email Address: ______________________

EMERGENCY CONTACT

Name: ______________________ Relationship to Student: ______________ Phone Number: ______________

<u>By signing below, I understand and acknowledge I have read and understand this consent</u>:

I give permission for my child/self to obtain routine health services at the School-Based Health Center.
All insurances will be billed at time of visit. No out-of-pocket costs for medical services rendered in school. No one will be refused services due to the inability to pay.

RELEASE OF INFORMATION AND PAYMENT AUTHORIZATION
I authorize the release of any medical or behavioral health information necessary to process my claim. I also authorize payment of health benefits to Child & Family Agency for services provided.

CONSENT AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES
I understand and acknowledge that I have read and understand this consent and I have received CFA's Notice of Privacy Practices currently in effect. I understand that information regarding how CFA will use and disclose my information can be found in CFA's Notice of Privacy Practices. I understand my consent is effective for as long as CFA maintains my protected health information.

AUTHORIZATION FOR EXCHANGE OF HEALTH AND EDUCATION INFORMATION
I give permission to allow Child & Family Agency (CFA) to exchange as needed information with my child's medical provider, school nurse, and key school personnel in order to effectively care for my child.

I also certify that the health information provided is accurate to the best of my knowledge and understand that incorrect information can be dangerous to the patient's health. I will notify the School-Based Health Center of any changes to medical information.

Signature of Parent/Legal Guardian/Personal Representative (or Student if over 18 years old): ______________________________

Print Name: ______________________________ **Date:** __________

By signing above, I understand that this authorization is valid until I revoke this authorization. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, if received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Education Rights and Privacy Act.

Please also complete reverse side →

Did you know you can register online? Visit us at: www.childandfamilyagency.org