

2009-2010
Student Health Center Enrollment Form
Grades 6-12

Parents - Please complete and sign this enrollment form that allows your child to use the Student Health Center for one year. For special situations, students are allowed to complete and sign the enrollment form themselves. **(See consent section on back).**

Student Name _____			Date of birth _____			Gender: <input type="checkbox"/> male <input type="checkbox"/> female		
School _____			Grade level _____			Student ID # _____		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan native <input type="checkbox"/> Native Hawaiian/Pacific Islander								
<input type="checkbox"/> Other race (Specify) _____			<input type="checkbox"/> Two or more races (Specify) _____					
Are you Latino or Hispanic? <input type="checkbox"/> yes <input type="checkbox"/> no			What country were you born in? _____					
What is the primary language spoken in your home? _____								
Address: _____			Zip _____			Home Phone: _____		
Parent work phone: _____			Parent cell phone: _____			Student cell phone: _____		
Parent(s) or legal guardian(s) _____			Address (if different than above) _____					

Student Health Information

Please complete the following important information that will help us to know about your child's health needs:

Doctor/Health Care Provider: _____ Check here if your child does not have a health care provider:

My child had his/her last physical exam within the last two years. yes no don't know

My child will need immunizations this year. yes no don't know

Significant past illnesses, injuries or hospitalizations _____

Allergies: _____ Asthma: yes no Cardiac disorder: yes no

Other physical, dental or mental health problems: _____

Current medications: _____

Family Health History – Please check off where there is a family history of any of the following health conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Immune disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Tuberculosis |

Does your child receive yearly dental care? yes, at a private dentist
 yes, at Community Dental
 no, we need a dentist/dental care

If your child does not have a dentist or goes to Community Dental, would you like your child to get preventive dental services at school? yes no

Does your child have dental pain (toothache)? yes no

(See back)

Health Insurance Information (VERY IMPORTANT – PLEASE COMPLETE)

Do you have Medicaid/MaineCare coverage? ____ yes ____ no Do you have private insurance coverage? ____ yes ____ no

If employed, name of insured parent's employer _____ Check here if you have no health insurance ____

If you have MaineCare or private insurance, please provide us with a photocopy of your insurance card or fill-in the information on the blank sample card shown below. You may also have your child bring the card to us at the health center and we will make a copy.

Title of card _____
Insured person's name _____
Policy ID or Medicaid # _____
Group # _____
Physician _____

Consent to use the Student Health Center

I give permission for my child, _____, to use the Student Health Center for one year which may include receiving physical, dental or mental health services.

*** I understand that my signature indicates that I have received and read the Student Health Center Enrollment Information.**

*** I understand that my signature indicates that I have received a copy of the Privacy Notice.**

*** I understand that my signature also gives permission for Student Health Center staff to access my child's school health record and share pertinent health information between the Student Health Center staff and school nurse or school social worker when it is deemed appropriate for treatment purposes.**

*** I understand that my signature allows for pertinent physical, dental and mental health information to be shared between the Student Health Center staff and my child's doctor or dentist as well as personnel from Community Counseling Center when and if my child is accessing those services in order to facilitate treatment services.**

*** I understand that I may revoke this authorization at any time by written notice sent to the address below. Such revocation shall not affect any uses or disclosures permitted by your authorization while it was in effect.**

Parent/guardian signature _____ Date _____

Print Name: _____ Relationship _____

Students may sign for themselves in the following special situations:

1. Students who are 18 years old or older
2. Students who are married
3. Students who are emancipated (requires legal court action)
4. Students who are living independently (living separately from parent or guardian for at least 60 days and independent of parental support).

I am a student who fits into one or more of the four special situations listed above and can sign consent for myself. (Please circle the number(s) that fit your situation) - 1 2 3 4

Student Signature _____ Date _____

**Please return this form to the Student Health Center or school nurse; or mail/fax to:
City of Portland, Health & Human Services Department, Public Health Division
166 Brackett Street
Portland, ME 04102
Fax 874-8477**