CREC Schools of Excellence

School Based Health Centers

ENROLLMENT FORM

Student Name:		Date Of Birth:
Address:	City/State/Zip Code:	Student's Ss#:
School at time of enrollment:	Grade:	Gender:

STUDENT HEALTH HISTORY

Medications/Supplements (name/dose/freq)	Allergies (allergen/reaction)
Hospitalizations (reason/appx date)	Surgeries (type/appx date)

Medical History– if yes, please provide any other pertinent details

	YES	NO	If yes, explain
Problems with vision (glasses)			
Problems with ears or hearing			
Concussion (when?)			
Heart problems/chest pain/murmurs			
Asthma/trouble breathing/coughing			
Blood disease or disorder			
Seizures			
Diabetes/thyroid/endocrine			
Broken bones or dislocations			
Muscle or joint problems			
Eczema or acne			
Mono (when?)			
TB or positive skin test			
Dental problems			
Headaches or Migraines			
Stomach problems			

Mental Health History – if yes, please provide any other pertinent details

	YES	NO	
Anxiety			
Depression			
Loss/divorce issues			
Behavioral issues			
Smoking/Substance abuse			
Other			

Family History – if yes, please explain who and any other pertinent details

	YES	NO	
Family members with heart disease?			
Diabetes?			
Alcohol/drub abuse?			
Mental illness?			
Sudden Death?			

HEALTH CARE PROVIDERS

Preferred Pharmacy & Town/Phone if Available	Preferred Hospital &Town/Phone if Available:
Student's Specialists or Other Health Care Providers (Specialty, Name &Town/Phone if Available):	

INSURANCE INFORMATION AND PERMISSION

Please provide a copy of all insurance cards (front and back) if possible. Copies can be made at the school.

Is patient insured? □Yes □No If so, please complete below	Subscriber (Primary Insured) Is: □Student □Parent/Guardian □Other:
Insurance Carrier Name:	ID #:

Complete Below Only If The Student Is Not The Subscriber (Primary Insured)

Primary Insured's Name:	Insured's DOB:	Insured's SS#:
Insured's Employer:	Relationship to Student	

The information above is accurate to the best of my knowledge, and I will inform the school and SBHC staff of any changes to the student's information as soon as possible.

____________________________ ____________________________ ________________

Parent/Guardian Signature Parent/Guardian Printed Name Date

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ENROLLMENT, AUTHORIZATION FOR TREATMENT AND EXCHANGE OF PROTECTED HEALTH INFORMATION, INSURANCE AUTHORIZATION AND HIPAA CONSENT AND ACKNOWLEDGEMENT
Please cross out any records you do not want shared, any persons with whom you do not want the records shared or any services to which you do not want your child to have access as allowed by law.

I understand that information regarding how Capitol Region Education Council (Practice) will use and disclose Protected Health Information (PHI) can be found in Practice's Notice of Privacy Practices which I have had the opportunity to review. I authorize the Practice to exchange, use or disclose, verbally, electronically or in writing all PHI maintained at any time as deemed necessary. Signing the authorization to exchange information is voluntary and Practice may not require me to sign this authorization before Practice provides me with treatment. Information exchanged may include:

- Medical Records: including history, examinations, intake/progress notes, prescription information, health summaries, diagnostic test results (laboratory or imaging), immunization records, treatment plans and appointments scheduled. This may include the electronic submission of prescriptions to a pharmacy through an electronic health record.

I give my child listed above permission to participate in the School-Based Health Center (SBHC) for medical (including laboratory and diagnostic services), dental and mental health services as needed and available. I understand that my child's Primary-Care Provider (PCP) continues to oversee his/her care and that I am responsible to ensure that the PCP receives copies of any records or treatment plans sent home. I have read the SBHC Introductory Letter or Flyer and have had the opportunity to ask questions and have them answered to my satisfaction. I understand that I can contact the School Nurse or SBHC staff at any time with questions or concerns. I understand that the authorization for treatment will remain in effect as long as my student remains in a CREC school

I have the right to revoke the authorization to exchange information or consent at any time by providing a signed, written notice of such revocation to Practice. A description of my right to revoke my authorization is set forth in Practice's Notice of Privacy Practices. This consent is effective for as long as Practice maintains PHI for the patient listed above unless revoked by the student if over 18 years of age, otherwise by the student's parent or legal guardian at any time pursuant to the CT General Statute 19(a)-14c(b) and 17a-688(d) related to Adolescent Rights to Treatment and Confidentiality.

I request that payment of authorized Insurance, Medicaid and Medicare benefits be made on my or my child's behalf to CREC for any services furnished by the CREC SBHC or Mental Health Clinic. I authorize any holder of medical information about me or my child to release to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) and its agents or my insurance company any information needed to determine the benefits payable.

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Parent/Guardian Signature Parent/Guardian Printed Name Date

Authority of Personal Representative to Sign for Patient (check one): □ Self □ Parent □ Guardian □ Power of Attorney □ Other:____