THIS SECTION FOR SBHC OFFICE TO COMPLETE

1. School-Based Health Center: **2. Client Identifier:**

School-Based Health Center Enrollment Form
Massachusetts Department of Public Health

3. Today's Date: __ __ / __ __ / __ __ __ __
(Enrollment Date)

4. Name: ____
(First, Last)

5. Date of Birth: __ __ / __ __ / __ __ __ __

6. Gender: ☐ Female ☐ Male ☐ Transgender

7. Zip Code (Primary Address): __ __ __ __ __

8. Are you Spanish/Hispanic/Latino? ☐ Yes ☐ No ☐ Unknown/Not specified

9. What is your ethnicity? (You can specify more than one)

☐ African (Specify) ____________________
☐ African American
☐ American
☐ Asian Indian
☐ Brazilian
☐ Cambodian
☐ Cape Verdean
☐ Caribbean Islander
☐ Chinese
☐ Colombian
☐ Cuban
☐ Dominican
☐ European
☐ Filipino
☐ Guatemalan
☐ Haitian
☐ Honduran
☐ Japanese
☐ Korean
☐ Laotian
☐ Mexican, Mexican American, Chicano
☐ Middle Eastern
☐ Other (Specify) __________________
☐ Portuguese
☐ Puerto Rican
☐ Russian
☐ Salvadoran
☐ Vietnamese
☐ Unknown/ Not specified

10. What is your race? (You can specify more than one)

☐ American Indian/Alaska Native ☐ Black ☐ White ☐ Other (Specify) ____________________
☐ Asian ☐ Native Hawaiian or Pacific Islander ☐ Unknown/Not specified

11. In what language do you prefer to discuss health-related concerns? ____

12. In what language do you prefer to read health-related materials? ____

13. Do you have health insurance? ☐ Yes ☐ No ☐ Unknown ☐ No – Health Safety Net/HSN/Free Care

14. If yes, what is the name of your primary insurance?

☐ MassHealth: *Plans may include:*
Boston Medical Center HealthNet Plan
Fallon Community Health Plan
Neighborhood Health Plan
Network Health Plan
Health New England

☐ Children's Medical Security Plan
☐ Aetna
☐ Blue Cross/Blue Shield
☐ Champus Tricare
☐ Cigna
☐ Fallon (Non MassHealth)

☐ Other (Specify)______________________
☐ Harvard Pilgrim
☐ John Hancock
☐ Network Health Plan (Non MassHealth)
☐ United Health NE (Non MassHealth)
☐ Tufts

15. In the last 12 months, did you receive a complete physical exam? ☐ Yes ☐ No ☐ Unknown

16. In the last 12 months, where did you go most often for healthcare?

☐ Office, clinic or community health center ☐ Hospital ER ☐ Other (Specify) ________________________
☐ School-based health center ☐ Didn't go for care ☐ Unknown

17. Do you have dental insurance? ☐ Yes ☐ No ☐ Unknown

18. In the last 12 months, did you receive a comprehensive dental exam? ☐ Yes ☐ No ☐ Unknown

19. Are you a student? ☐ Yes ☐ No

20. If no, please indicate how you became a client of this school clinic. (Choose the one that is most relevant)

☐ Graduate of School ☐ Child of Student ☐ Relative of Student ☐ Community Member ☐ School Staff

21. Do you receive special education services? ☐ Yes ☐ No ☐ Unknown

22. Do you receive free or reduced-cost school lunches? ☐ Yes ☐ No ☐ Unknown

23. Do you have a chronic health condition? *(Please turn form over for examples of chronic health conditions)* ☐ Yes ☐ No ☐ Unknown

Here are some examples of chronic health conditions:

Asthma	Diabetes	Allergies	Attention Deficit Disorder (ADD/ADHD)
Hypertension	Depression	Eczema/Skin Rashes	

Please ask the School-based Health Center staff if you have any questions about this or any other parts of this form.

Parental/Guardian Consent for Treatment and Exchange of Information Form

Please complete **BOTH SIDES** *of this consent form and return to School Based Health Center or School Nurse*

Section A

Student Information

Student's Last Name | Student's First Name

Student's Home Address

Student's Home Phone | Student's Cell Phone

Student's House office at BHS | Year of Graduation

Consent to Medical/Dental Treatment

I give consent for my son/daughter to receive routine and preventative health care services offered at the Community Health Center of Cape Cod (CHC) School Based Health Center as described in the document provided to me as of this date entitled Community Health Center of Cape Cod School Based Health Center at Barnstable High School, and in accordance with the laws of the Commonwealth of Massachusetts. I have been provided with information and have been offered the opportunity to discuss the services offered at the School Based Health Center. Permitted Health Care Services include the following: evaluation, diagnosis and treatment of minor or acute illnesses and injuries; dental care; general health assessments and examinations (e.g., health assessments); management of injuries and long-term illness; standard immunizations; and basic gynecological care.

I also give permission for my son/daughter to receive health and emotional health counseling and education for: diet and weight control; tobacco use cessation; drug and alcohol prevention; emotional problems; HIV prevention; pregnancy prevention, including abstinence counseling; and laboratory and screening tests for minor and acute illnesses, including TB.

I agree to the following as needed for appropriate health care: exchange of medical information between the School Based Health Center and other healthcare providers; exchange of medical information between the School Based Health Center and the School Nurse (including disclosure of student record information to the School Based Health Center by the School Nurse); referral to the student's primary healthcare provider or other healthcare provider. I give permission for the Barnstable Public School Teachers, House Masters, Guidance Counselors, School Nurses, and other professional staff who are directly involved with my child to speak with and obtain appropriate information from the CHC Nurse Practitioners and Clinical Therapists for the purpose of treatment and planning for treatment.

I authorize the School Based Health Center to release information regarding treatment to third-party payers and others for the purpose of billing or for any reason that may be required to comply with the statues of regulations in accordance with accepted medical practice.

Signature

I have read and understood this consent form and give my permission which will remain in effect as long as my child is enrolled at Barnstable High School and receives services from the CHC School Based Health Center. I understand that I can withdraw or modify my consent in writing at any time.

Signature of Legal Guardian | Date

Legal Guardian Name (please print)

Daytime Phone | Cell

Emergency Contact | Phone

Please complete **BOTH SIDES** ***of this consent form and return to***
School Based Health Center or School Nurse,
Room 1306, Barnstable High School
(508) 790-7200

Section B

Medical Information

Student's Last Name **Student's First Name**

Student's Regular Doctor's Name

Allergies

Health Insurance Information: Please check all that apply

☐ Health Insurance or HMO

Name of Health Insurance or HMO

Policy Number **Group Number (if any)**

Policy Holder's Name

Policy Holder's Address

Town Zip **Phone**

Name and Address of Policy Holder's Employer

☐ Secondary Insurance

Name **Policy Number**

☐ MassHealth

☐ No Insurance: Please call 508 790-7200 for further information

Emergency Contact

Person to Notify in Case of Emergency **Relationship** **Phone**