Client ID: _____

Staff Initials: _____

UCFS School Based Health Center at Norwich Public Schools Enrollment Form

UCFS Healthcare
SCHOOL-BASED HEALTH CENTER at Norwich Public Schools

If you would like this information translated into Spanish, Haitian Creole or Chinese, please contact Sheila Osko: 860 823 4205, x 2509.
Si austed le gustaríaestainformacióntraducida al español, criollohaitiano o chino, sírvasecontactar a Sheila Osko: 860 823 4205, x2509.
Si ou ta renmenenfomasyonsatradui an Español, KreyólAyisyenoubyenChinwa, tanprikontakte Sheila Osko: 860 823 4205, x 2509.
如果您想这些资料翻译成西班牙文，海地语或中文，请联系 Sheila Osko: 860 823 4205, x 2509.

The UCFS School Based Health Center at Norwich Public Schools offers 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 at 47 Town Street, Norwich.
Dental Health – Dental Hygiene Cleanings, Preventive Care (specific times of the year by appointment only)

Who Can Receive Services? Only Norwich Public School Students can receive services at the School Based Health Center. 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 www.ucfs.org.

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.

For any questions or to request more information please email sbhc@ucfs.org or call 860-822-4909

Student Information:

Student Name: _____ Date of Birth:_____

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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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) _____

Client ID: _____

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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: _____

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UCFS Healthcare
SCHOOL-BASED HEALTH CENTER at Norwich Public Schools

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	

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Household Makeup/Relationships – Please indicate who presently lives with the student and if your child is having difficulty with those listed.		
Name	**Relationship to Child**	**Describe your child's relationship with person**

Pregnancy							
Was this child a planned pregnancy?	☐	Yes	☐	No	☐	Unknown	
At what point was the mother's pregnancy known?							
Were there any medical/health problems for the mother or baby during this pregnancy?	☐	Yes	☐	No	If yes, what were they?		
Did the mother smoke or drink during the pregnancy?	☐	Yes	☐	No	If yes, please explain what, how much, how often:		
Did any other household member smoke or drink?	☐	Yes	☐	No			
Did mother use drugs (legal or illegal) during pregnancy?	☐	Yes	☐	No	If yes, please explain what, what for:		
How was the mother's diet during the pregnancy?	☐	Good	☐	Poor	Please explain:		
Labor and Deliver							
Was the baby born on time?	☐	Yes	☐	No	If no, please explain:		
Length of labor			Birth Weight				
Any complications during labor or delivery?	☐	Yes	☐	No	If yes, please explain:		
Was the mother medicated during the delivery?	☐	Yes	☐	No	If yes, name of medication:		
Describe baby's condition at birth:							
Did the baby require any specialized medical procedures?	☐	Yes	☐	No	If yes, please explain:		
Was the father present/and or participant in the delivery?	☐	Yes	☐	No			
How did the mother feel emotionally when the baby was born?							
For whom was baby named?							
Was baby breast-fed:	☐	Yes	☐	No	☐	Unknown	Age weaned:
Was baby fed:	☐	on schedule	☐	on demand			
Was baby a good or picky eater?							

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Early Developmental Milestones					
For each of the next three areas, indicate the child's developmental history by circling one description. The "average" period is only a rough idea of what is average since every developmental milestone actually involves a range of several months. Circle "early" or "late" only if you are sure the child's development was different from that of most other children.					
Gross Motor Skills:					
Crawled	Early	Average (6-9 months)		Late	
Walked alone	Early	Average (6-9 months)		Late	
Language:					
Followed simple commands	Early	Average (12-18 months)		Late	
Used single-word sentences	Early	Average (12-24 months)		Late	
Self-Help:					
Toilet trained	Early	Average (13-36 months)		Late	
Toilet training was	Easy	Difficult		If difficult, please explain:	
Does child continue to have toileting accidents?	☐	Yes	☒ No	If yes, please explain:	
As an infant or toddler the child was:					
☐ Too calm		☐ Shy and inhibited			
☐ Calm and reasonable active		☐ Neither shy nor outgoing			
☐ Irritable and very active		☐ Very outgoing and liked people			
List any significant developmental problems (i.e. speech delays):					
Developmental milestones within normal range:		☐ Yes	☐ No	If no, please explain:	

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Consent for Services:

Student Name:_____ Date of Birth:_____

Consent: Please check Yes or No after each statement and sign at the bottom. By signing below, I understand and acknowledge I have read and understand this consent.

☐ **YES** ☐ **NO** 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.

☐ **YES** ☐ **NO** **Medical Services provided at 47 Town Street, Norwich**
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.

☐ **YES** ☐ **NO** **Behavioral Health Services (therapy)**

☐ **YES** ☐ **NO** **Smiles on the Move Mobile Dental**

☐ **YES** ☐ **NO** **Dental** – I give permission for my child to treated and receive services deemed necessary by the staff at United Community & Family Services, Inc. ("UCFS"), including dental cleanings, fluoride treatments, examinations, sealants and x-rays if dental is a selected services.

☐ **YES** ☐ **NO** **Dental** – I understand that my child will receive all eligible dental services, including sealants.

☐ **YES** ☐ **NO** **Dental** – I understand I am responsible to pay for the services rendered if I do not have insurance. A total of $40 will be charged which includes exam, cleaning, fluoride and x-rays.

☐ **YES** ☐ **NO** **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.

☐ **YES** ☐ **NO** **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.

☐ **YES** ☐ **NO** **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.

☐ **YES** ☐ **NO** I acknowledge that I have received the UCFS Patient Rights and Responsibility Policy.

Printed Name _____ **Relationship** _____

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