School Based Health Centers
BHS, WIS & Murphy Schools

Permission Form

Please complete and sign this form and return to your child's School Based Health Center.

Today's Date: **Grade:** **School:**

Student's Name: Sex: Female ☐ Male ☐ Other ☐

Home Address: City: State: Zip:

Student's Social Security # **Birthdate:**

Child's Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/ Latino

Child's Race: ☐ Black or African American : ☐ White ☐ American Indian or Alaskan Native ☐ Native Hawaiian/Other Pacific Islande
☐ Asian ☐ Other ☐ Unknown

PARENT INFORMATION:

Mother: Father:

Address: Address:

Home Ph: Work: Home Ph: Work:

Cell: Email: Cell: Email:

Parents: Married Divorced Separated Mother Deceased Father Deceased

Guardian of Student: Relationship to Student:

Address:

Home Phone: Work Phone: Cell Phone:

Emergency Contact: (please note how the person is related to your child)

Name Phone: Relationship

Number of people in household: Need Interpreter? Yes ☐ No ☐ Preferred Language

Does your child receive free or reduced school lunch? Yes ☐ No ☐

Health Care Provider: Primary Care Physician Phone #:

Dentist: Preferred Pharmacy:

Insurance Information: ***Please provide a copy of your current insurance card(s) to the SBHC office.****

Insurance Company

Address/Phone Phone#

Policy # Group Name and #

Policy Holder's Name Birthdate: S.S.#

Relationship to Student: Occupation:

Insurance Type: (Please check one) Husky A ☐ Husky B ☐ No Insurance ☐ Private/Commercial ☐ Unknown ☐ Other ☐

Employer Name Phone#

Employer Address City: State: Zip:

STUDENT'S MEDICAL HISTORY Please check all that apply and explain if your child has a history of the following:

- ☐ Heart Problems
- ☐ Headaches
- ☐ Weight Problems
- ☐ Asthma
- ☐ Heart Murmur
- ☐ Stomach Problems
- ☐ Vision Problems
- ☐ Allergies
- ☐ Dental Problems/Needs
- ☐ Skin Problems
- ☐ Ear Infections
- ☐ Diabetes (Insulin Yes No)
- ☐ Chicken Pox (Year:_____)
- ☐ Upper Respiratory Infections
- ☐ Musculoskeletal Problems
- ☐ Other:_____

Explain:

Please answer the following questions. If yes, please explain. Is your child currently or have they had -

Y ☐ N ☐ Allergies to food, medicine, or other:

Y ☐ N ☐ Taking medications regularly (please list medications and dose):

Y ☐ N ☐ Hospitalizations/surgeries:

Female Students:
Has your child begun menstruating? Yes ____No _____ If no, have you discussed menstruation with her? Yes ____ No _____

Reproductive health care is available in the SBHC. Services may include: HIV/STD/AIDS education, counseling, testing and prevention, including condom distribution. Pregnancy testing and contraceptive services are available for female students.

Students Behavorial Health History: Please check all that apply and explain if your child has a history of the following:

- ☐ Anxiety
- ☐ School Attendance Problems
- ☐ Behavior Problems
- ☐ PDD/Autism
- ☐ ADHD/ADD
- ☐ Eating Disorders/Weight Problems
- ☐ Depression/Sadness
- ☐ Sleep Problems
- ☐ Alcohol/Drug Use
- ☐ OCD
- ☐ Academic Concerns

Explain:

Yes ☐ No ☐ **Currently in counseling:** Therapist/Provider:

Yes ☐ No ☐ **Current Agency Involvement:**

Yes ☐ No ☐ **History of counseling:** Dates : Therapist/Provider:

Please note any concerns that you would like to discuss with the School Based Health Center Staff:

I give my consent for **(Student's Name)** _____ to receive medical and/or mental health services at Branford SBHCs. I understand all services are confidential in accordance with Connecticut State laws, except in life-threatening or emergency situations. I give permission for the release and exchange of information between the SBHC staff and my child's health care provider. I also give permission for the SBHC staff to communicate with school personnel and to access my child's school and health record.
I do NOT want my child to receive the following SBHC services:

1)_____2)_____3)_____

I authorize Yale-New Haven Hospital to bill my insurance carrier and to release information regarding my treatment and/or services for the purpose of billing. I will not be responsible for paying for any service received at the SBHC. I understand that all medical records are the property of Yale New Haven Hospital. I acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that I can withdraw my consent to treat at any time through written notification

Parent/Guardian's Signature: **Date:**

Please Save and Email the completed Permission Form to the SBHC school secretary:

BHS: mmelillo@branfordschools.org **Walsh**: pclarke@branfordschools.org **Murphy**: stefappiano@branfordschools.org