

Your child's school has a  
**School-Based  
Health Center!**

School-Based Health Center  
(SBHC) staff can provide:

- Well child & annual physical exams
- Care for sick visits
- Care for chronic issues
- Counseling services
- Preventative dental care

*If your child is home sick you may still bring him/her to their SBHC to be seen.*

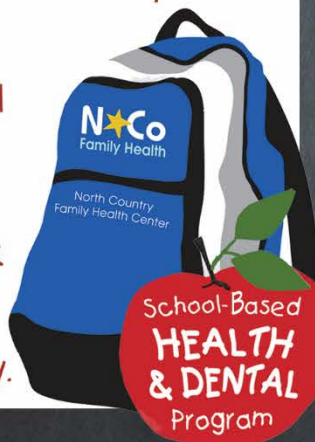
ALL students K-12 are eligible.  
(Pre-K & Headstart are also eligible.)

ALL students with or without insurance are eligible.

ALL students with their own family doctor or dentist are eligible. We can serve as your primary care provider or work with your healthcare provider to coordinate care.

There are no co-pays or deductibles for services provided in school.

Many parents choose to enroll their children just in case they need it -- no loss of work for parents and students are seen quickly.



# Healthy Students Learn **BETTER!**

North Country Family Health Center  
**School-Based Health Centers**

South Jefferson Central School District  
Watertown City School District

Alexandria Central School District\*  
Copenhagen Central School\*  
Lowville Academy & Central School District\*  
South Lewis Central School District\*

*\* Offering Dental Services Only*



**NoCo** North Country  
**Family Health Center**

When school is closed patients can reach us 24/7

**Medical ~ 315.782.6400**

**Dental ~ 315.788.9834**

For more information on each School-Based Health Center's  
contact information visit [www.NoCoFamilyHealth.org](http://www.NoCoFamilyHealth.org)



Today's Date: \_\_\_\_\_

### School-Based Health Center 2017-18 ENROLLMENT FORM

Student's name: \_\_\_\_\_  
(LAST) (FIRST) (FULL MIDDLE)

Student's school: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher/Homeroom: \_\_\_\_\_

Student's birthdate: \_\_\_\_\_ Sex at birth:  M  F Student's SS#: \_\_\_\_\_

**RACE:**  White  Native Hawaiian  Other Pacific Islander  
 Black/African American  American Indian/Alaska Native  
 Asian  Unreported/Refused to Report

**ETHNICITY:**  Hispanic or Latino  
 Non-Hispanic or Non-Latino  
Preferred **LANGUAGE:** \_\_\_\_\_

**MEDICAL/DENTAL PROVIDER INFORMATION**

**My child does not have a regular doctor or dentist.**

**My child regularly goes to another doctor and/or dentist.** However, I would like to use the School-Based Health Center when necessary. I understand that my child's healthcare provider will receive reports following visits.

My child's doctor's office: \_\_\_\_\_ Date of last physical exam: \_\_\_\_\_  
*(Please provide a copy of last exam)*

My child's dentist's office: \_\_\_\_\_ Date of last dental exam: \_\_\_\_\_

**I would like my child enrolled in:**  Medical  Dental  Behavioral Health  
*Check "X" which service(s) you would like to enroll your child in. You may do a combination of any of our services.*

**Preferred Drug Store:**

Name: \_\_\_\_\_ Location: \_\_\_\_\_

**PARENT/GUARDIAN CONTACT INFORMATION:**

<p>Name: _____</p> <p>Mailing address: _____ _____</p> <p>Home phone: _____ Cell: _____</p> <p>Okay to leave a message or voicemail? Y N</p> <p>Employer: _____</p> <p>Work phone: _____</p> <p>SS#: _____ Birthdate: _____</p> <p>Relationship to student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____</p> <p>Email: _____</p> <p>Okay to email in non-emergency situations? Y N</p>	<p>Name: _____</p> <p>Mailing address: _____ _____</p> <p>Home phone: _____ Cell: _____</p> <p>Okay to leave a message or voicemail? Y N</p> <p>Employer: _____</p> <p>Work phone: _____</p> <p>SS#: _____ Birthdate: _____</p> <p>Relationship to student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Step-parent <input type="checkbox"/> Guardian <input type="checkbox"/> Other: _____</p> <p>Email: _____</p> <p>Okay to email in non-emergency situations? Y N</p>
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Student's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(LAST) (FIRST)

Student's mother's maiden name: \_\_\_\_\_

Who may make medical/dental decisions for this student?  Mother  Father  Both parents  Other: \_\_\_\_\_

Who does the child live with?  Mother  Father  Both parents  Other: \_\_\_\_\_

**Emergency Contact** (Relation to child): \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/guardian responsible for medical/dental bills: \_\_\_\_\_ SS#: \_\_\_\_\_

If not listed above, address: \_\_\_\_\_

**MEDICAL/DENTAL INSURANCE INFORMATION:** (Check all that apply. This information is found on your insurance card.)

**Primary Medical Insurance:** Insurance company: \_\_\_\_\_

Insurance phone: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy holder's information: Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Medical Insurance:** Insurance company: \_\_\_\_\_

Insurance phone: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy holder's information: Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

**Primary Dental Insurance:** Insurance company: \_\_\_\_\_

Insurance phone: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy holder's information: Name: \_\_\_\_\_

DOB: \_\_\_\_\_ SS#: \_\_\_\_\_ Phone: \_\_\_\_\_

**Secondary Dental Insurance:** Do you have secondary dental insurance?  Yes  No

If yes, please indicate what type of insurance it is \_\_\_\_\_

**MEDICAL / SURGICAL / DENTAL HISTORY:** Has the **child** had any history of, or conditions related to, any of the following:

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> ADHD/Mental Health | <input type="checkbox"/> Cardiac issues    | <input type="checkbox"/> Growth problems   | <input type="checkbox"/> Seizures    |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Chicken Pox       | <input type="checkbox"/> Kidney            | <input type="checkbox"/> Sickle Cell |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Chronic sinusitis | <input type="checkbox"/> Latex allergy     | <input type="checkbox"/> Thyroid     |
| <input type="checkbox"/> Blood disorder     | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Pneumonia history | <input type="checkbox"/> Urinary     |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Ear aches         | <input type="checkbox"/> Rheumatic fever   | <input type="checkbox"/> Other       |

Past surgeries/hospitalizations: \_\_\_\_\_

Does child have any **food, environmental, or drug allergies**?  No  Yes If Yes, **ALLERGIES & REACTIONS** include: \_\_\_\_\_

What **medications/dose** is the child taking? Please include any supplements, herbs, vitamins, and over the counter medications too.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Student's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 (LAST) (FIRST)

Do you have any concerns about your child's emotions/behaviors?  No  Yes, explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

*(If you would like your child to be seen by a counselor, please contact your school's School-Based Health Center).*

Does your child have any developmental delays or problems?  No  Yes, explain: \_\_\_\_\_

Does your child have any dental concerns?  No  Yes, explain: \_\_\_\_\_

Has the child had any problems with dental treatment in the past?  No  Yes, explain: \_\_\_\_\_

Has the child ever suffered injuries to the mouth or teeth?  No  Yes, explain: \_\_\_\_\_

What type of water does your child drink?  City water  Well water  Bottled water  Filtered water

Does your child see a healthcare specialist?  No  Yes, name of provider: \_\_\_\_\_  
 ( For example, a cardiologist, dermatologist, or psychiatrist etc.)

**FAMILY HISTORY:** Check any of the following a relative has had. **Please include both sides of the family if you can.**

	Mom	Dad	Sis/Bro	Aunt/Uncle	G-parent
Allergies/eczema					
Asthma					
Cancer					
Diabetes					
Hepatitis					
High blood pressure					
High cholesterol					
HIV positive					
Kidney disease					

	Mom	Dad	Sis/Bro	Aunt/Uncle	G-parent
Mental health disorder					
Migraines					
Obesity					
Stomach/GI problems					
Seizure disorder					
Stroke					
TB					
History unknown					
Other:					

**SIBLINGS:** *(Include names and ages)*  
 \_\_\_\_\_  
 \_\_\_\_\_

\_\_\_\_\_

Has your child or a close household contact ever: *(check all that apply)*

- |   |   |
|---|---|
| <input type="checkbox"/> Had a positive TB screen   | <input type="checkbox"/> Been a migrant worker                |
| <input type="checkbox"/> Been infected with tuberculosis of a lung or taken care of a TB patient  | <input type="checkbox"/> Taken IV street drugs                |
| <input type="checkbox"/> Lived in or visited Latin America, SE Asia, Caribbean, or Eastern Europe | <input type="checkbox"/> Been exposed to someone with TB      |
| <input type="checkbox"/> Had concerns about lead poisoning/problems                               | <input type="checkbox"/> Been in prison or a homeless shelter |
| <input type="checkbox"/> Taken medicine called corticosteroids                                    |   |

# of smokers in household \_\_\_\_\_

**As a Federally Qualified Health Center we must ask that you complete the following:**

Where did your child sleep last night?  
 In a house/apartment  In a shelter  Car  Do not have a place  With a friend/relative

What is the household annual income \$ \_\_\_\_\_

What is the family household size? \_\_\_\_\_



**CONSENT FOR SCHOOL-BASED HEALTH & DENTAL SERVICES**

I give my consent for my child, \_\_\_\_\_ to receive services provided by the staff of the North Country Family Health Center (NCFHC) School-Based Health/Dental Program. Also, I give my consent for NCFHC staff to have access to my child's school health records and copies of my child's most recent physical exam. I give my permission for the release of my child's reports to his/her healthcare provider and/or the school nurse to coordinate his or her care. I authorize insurance and/or Medicaid payments for services rendered for my dependent directly to NCFHC and the release of medical information necessary to process claims to my insurance carrier. I understand that NCFHC will share patient health information according to state and federal law for treatment, payment, and operations.

Services may include, but are not limited to, the following: comprehensive physical/dental examinations; treatment of illness and injury; dental treatment, and monitoring of chronic illness.

I understand that every effort will be made to contact me prior to treatment. The staff of the North Country Family Health Center believes that parental involvement is essential in keeping children healthy and will encourage each student to involve his or her parents in healthcare decisions. We encourage parents to visit or call the School-Based Health Center at any time.

★ Parent/Guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Student's name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**CONFIDENTIALITY (HIPAA) NOTICE**

North Country Family Health Center is committed to maintaining the privacy of your protected health information (PHI). Our promise is that your medical records and other PHI will only be released from our practice with a properly executed authorization form from you, the patient, or your representative, except for certain instances. These instances are described in our Notice of Privacy Practices. The Notice is available for you to read in our office or on our website, [www.NoCoFamilyHealth.org](http://www.NoCoFamilyHealth.org). The following are possible ways in which we may use or disclose your PHI: These are only examples.

1. When our medical/dental staff is caring for your child, we will review your child's medical/dental history.
2. Our administrative staff may audit your child's medical/dental records for completeness and quality assurance.
3. We may need to tell your insurance plan certain information so that we may receive payment for services.

You have a right to review the Notice before signing this consent. You have the right to ask us to restrict how we use your PHI. We will provide you with a form on which you can make your written request for restrictions. We don't have to agree to the restriction, but if we do, we are bound by the agreement. We may make changes to the Notice. Upon your request, we will provide you with any revisions.

★ **Continued on back . . .** ★

By signing this form you consent to our use and disclosure of PHI as described in our Notice of Privacy Practices. You have the right to revoke this consent in writing. You have the right to an accounting of the disclosures of your PHI for other treatment, payment and healthcare operations. I have been informed and understand my rights regarding the possible ways in which North Country Family Health Center may use and disclose my/my child's protected health information. In addition, I acknowledge that North Country Family Health Center uses a third party to carry out healthcare functions such as appointment reminders, and after hours telephone triage.

\_\_\_\_\_  
Parent/Guardian signature (If child is 18 they may sign for themselves)

\_\_\_\_\_  
Date

## REQUEST TO OBTAIN INFORMATION

**Required only if child has a provider other than North Country Family Health Center.**

**The New York State Department of Health requires that all students enrolled in a School-Based Health Center have a yearly comprehensive physical exam.**

In order to help the School-Based health/dental staff best meet my child's healthcare needs, I authorize my child's Primary Care Provider/Dentist to release my child's medical/dental information, including copies of the physical exam, immunization records, and other health information necessary to provide medical treatment **and/or** copies of dental records, medical history, current dental x-rays, and other information necessary to provide dental treatment.

I agree to allow my child's personal health/dental information, as described above, to be sent to North Country Family Health Center. I understand this is voluntary. I understand that North Country Family Health Center will protect this information under federal privacy regulations.

- I understand that I may see and receive a copy of the information described on this form if I ask for it.
- I understand that I may revoke this permission at any time by notifying my child's School-Based Health Center in writing. If I do, it won't have any effect on any actions taken before they receive the revocation.
- I understand that my child's health/dental care and payment for my child's care will not be affected if I do not sign this form.
- This permission form expires one calendar year after the date below.



\_\_\_\_\_  
Parent/Guardian signature (If child is 18 they may sign for themselves)

\_\_\_\_\_  
Date

FOR MEDICAL RELEASE: *Name and address of child's Primary Care Provider (PCP) or Practice:*

FOR DENTAL RELEASE: *Name and address of child's Dentist or Dental Group:*

Child's name:

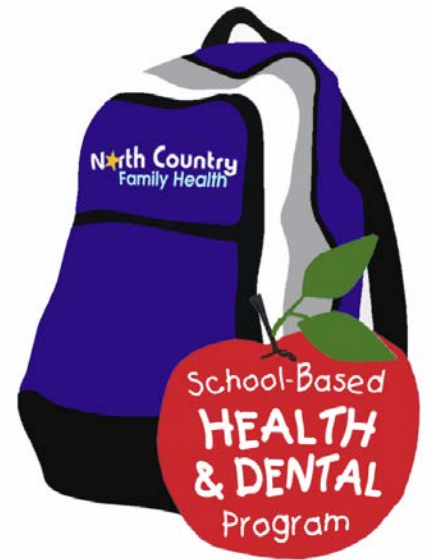
Child's birthdate:

Child's address:

\*This information may contain HIV related information. If you experience discrimination because of the release of HIV or other medically related information, you may contact the NY State Division of Human Rights at 212-870-8624. This agency is responsible for protecting your rights.

For Office Use Only: Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

# Attention Parents



## Not Yet Enrolled?

### Why Not --- It's Easy!

ALL students in your child's school are eligible to enroll in our School-Based Health & Dental Program regardless of income or current healthcare provider. Enrollment in the School-Based Health & Dental Program is a great back-up plan in case your child gets ill at school. All School-Based services are provided with no out-of-pocket cost, which means no co-pays or deductibles for parents.

## Already Enrolled?

Please take the time to update this packet ~ including any health history changes from the past year, address changes, or changes in insurance information and be sure to sign the confidentiality and consent form (last page).

### North Elementary

Please Note : ALL elementary students can receive medical, dental, and behavioral health services at North Elementary.

Medical & Behavioral Health . . . . Monday - Friday 7:30 a.m. - 3:00 p.m.

Dental . . . . Mondays (starting late fall).... 7:30 a.m. - 3:00 p.m.

### Ohio Street Elementary

Dental . . . . Thursdays (starting spring 2018) 7:30 a.m. - 3:00 p.m.

### Case Middle School

Medical & Behavioral Health . . . . Mondays 7:30 a.m. - 12:00 p.m.

Wednesdays & Fridays 7:30 a.m. - 3:00 p.m.

### Harold T. Wiley School

Medical & Behavioral Health . . . . Mondays 12:30 p.m. - 3:00 p.m.

Tuesday & Thursdays 7:30 a.m. - 3:00 p.m.

Dental . . . Tuesdays, Wednesdays, Thursdays, & Fridays (restorative) 7:30 a.m. - 3:00 p.m.

### Watertown High School

Medical & Behavioral Health . . . . Mondays - Fridays 7:30 a.m. - 3:00 p.m.

Students are transported to appointments via school transportation. Parents may bring their son/daughter to their appointment if they are available.



# Attention Parents



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## Already Enrolled?

Please take the time to update this packet ~ including any health history changes from the past year, address changes, or changes in insurance information and be sure to sign the confidentiality and consent form (last page).

## Where can my child receive care?

### Mannsville Manor Elementary

Medical . . . . . Tuesdays & Fridays, and every other Thursday 7:30 a.m. - 3:00 p.m.

Behavioral Health . . . . . Mondays & Wednesdays 7:30 a.m. - 3:00 p.m.

Dental . . . . . Mondays 7:30 a.m. - 3:00 p.m.

### Maynard P. Wilson Elementary

Medical . . . . . Mondays & Wednesdays, and every other Thursday 7:30 a.m. - 3:00 p.m.

Behavioral Health . . . . . Tuesdays, Thursdays, & Fridays 7:30 a.m. - 3:00 p.m.

Dental . . . . . Fridays 7:30 a.m. - 3:00 p.m.

### SJ Middle/High School at the Clark Building

Students at the Middle and High School can be seen at either Mannsville Elementary or Wilson Elementary for their medical and dental needs.

Dental . . . . . Wednesdays 7:30 a.m. - 3:00 p.m.

Parents may transport students to either School-Based Health Center, or students with driving privileges may drive themselves to appointments.