N★Co Family Health

Today's Date:

School-Based Health Center (SBHC)
Enrollment Form

What Services Do You Want to Enroll Your Student In? (Check All That Apply):	☐ Medical ☐ Dental ☐ Behavioral Health ☐ All Services Provided at Our School-Based Site

My Student's Information:

Last Name:	First Name:	Full Middle Name:
Date of Birth:	Sex at Birth: ☐ Male ☐ Female	Street Address:
Student's School:	Grade:	Teacher/Homeroom:

Biological Mother's First Name and Maiden Name:	Preferred Pharmacy Name: Address:
Student's Primary Care Doctor's Name:	☐ My Student Doesn't Have a Regular Doctor/Healthcare Provider
Student's Primary Dentist Name:	☐ My Student Doesn't Have a Regular Dentist

Parent/Guardian # 1 Information:	**Parent/Guardian # 2 Information:**
Name:	Name:
Relationship to Student: ☐ Father ☐ Mother ☐ Stepparent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other	Relationship to Student:☐ Father ☐ Mother ☐ Stepparent ☐ Guardian (Please Provide a Copy of Court Order) ☐ Other
Mailing Address (If Different than Student):	Mailing Address (If Different than Student):
Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No	Best Phone Number to Reach You: _____ ☐ Cell ☐ Home Okay to Leave a Message/Text: ☐ Yes ☐ No

Who Does My Student Live With: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Stepparent ☐ Other:

Who Will Make Healthcare Decisions for My Student: ☐ Father ☐ Mother ☐ Both Parents ☐ Guardian ☐ Stepparent ☐ Other:

Do We Have Permission to Call the Student's Emergency Contact You Provided to the School: ☐ Yes ☐ No

North Country Family Health Center, as a Federally Qualified Health Center, MUST Ask You to Complete the Following Questions: (PLEASE FILL OUT ALL SECTIONS BELOW RESPONDING FOR YOUR STUDENT):

Household Size & Income (Enter Child's Family Information):
Number of People in the Household: _____ Income $_____ ☐ Week ☐ Month ☐ Year

Student's Ethnicity: ☐ Not Hispanic, Latino/a, or Spanish ☐Mexican, Mexican American, Chicano/a
☐Puerto Rican ☐Cuban ☐Another Hispanic or Latino/a, or Spanish: _____

Student's Race: ☐White ☐Black or African American ☐American Indian/Alaskan Native ☐Native Hawaiian
☐Other Pacific Islander ☐Chinese ☐Japanese ☐Korean ☐Asian Indian ☐Other Asian: _____

Student's Primary Language: ☐English ☐Spanish ☐Other (Please Specify): _____

Primary Medical Insurance	**Primary Dental Insurance**
☐ My Student ***Has*** *Medical* Insurance ☐ My Student ***Does Not*** Have *Medical* Insurance Please contact our partnered Certified Application Counselor at NCPPC at 315-788-8533 ext. 228 to help enroll your student in a healthcare plan that is right for you and your family.	☐ My Student ***Has*** *Dental* Insurance ☐ My Student ***Does Not*** Have *Dental* Insurance Please contact our partnered Certified Application Counselor at NCPPC at 315-788-8533 ext. 228 to help enroll your student in a healthcare plan that is right for you and your family.
Insurance Company Name:	Insurance Company Name:
Medical Policy #:	Dental Policy #:

Student Name: _____ Date of Birth: _____

Billing Address of Insurance Company:	Billing Address of Insurance Company:
Policy Holder's Name and Date of Birth:	Policy Holder's Name and Date of Birth:
Policy Holder's Social Security #:	Policy Holder's Social Security #:
☐ I have additional ***Medical*** Insurance (Name of Insurance):	☐ I have additional ***Dental*** Insurance (Name of Insurance):

Required Medical History:

Has Your Student Been Diagnosed with Any of the Following? ☐ ADHD/Mental Health Issues ☐ Asthma ☐ Autism ☐ Cancer ☐ Cardiac Issues ☐ Chicken Pox ☐ Diabetes ☐ Growth Problems ☐ Kidney/Urinary Issues ☐ Latex Allergy ☐ Rheumatic Fever ☐ Seizures ☐ Thyroid Issues ☐ Tuberculosis ☐ Other (Please List):_____

Date of Your Student's Last Physical Exam: Provider Name:

Has Your Student Had Any Surgeries? ☐ No ☐Yes (Please List):

Has Your Student Been Hospitalized? ☐ No ☐Yes (Please List):

Has Your Student Been Referred to a Healthcare Specialist? ☐ No ☐ Yes (Name & Phone Number of Specialist):

Does Your Student Take Daily Medications: ☐ No ☐ Yes (Please List):

Does Your Student Have Any Allergies: ☐ No ☐ Yes (Please List):

Does Anyone in the Home Smoke or Vape? ☐ No ☐ Yes (Please List):

Do You Have a Family History for Any of the Following Conditions? (Mother, Father, Siblings, and/or Grandparents)
☐Stroke ☐Cancer ☐Obesity ☐Diabetes ☐Epilepsy ☐TB ☐Asthma ☐Sickle Cell Trait ☐Thyroid ☐ Mental Health
If Yes, Please Explain:

Cardiac Screening Questions:

Has Your Student Ever Been Told by a Healthcare Provider that They Have a Heart or Blood Pressure Problem?
☐ No ☐ Yes If Yes, Please Explain:

Since Your Student's Last Physical Exam Has Your Student Complained of: ☐Lightheadedness ☐Dizziness ☐Excessive Fatigue ☐Shortness of Breath ☐Passed Out After Exercise If Yes, Please Explain:

Is There a Family History of Sudden or Unexpected Death in a Person Less than 50 years old (Mother, Father, Siblings, and/or Grandparents)? ☐ No ☐ Yes If Yes, Please Explain:

Is There a Family History of: ☐Cardiomyopathy ☐ Marfan Syndrome ☐ Arrhythmia ☐Brugada Syndrome ☐ Long or Short QT Interval ☐Heart Attack at Age 50 or Younger ☐Any Other Heart Issue
If Yes, Please Explain:

Dental Services Screening Questions: Please Complete for Your Student if Requesting Dental Services:
☐ Requesting Services ☐ Not Requesting Services

Student Name: _____ Date of Birth: _____

Does Your Student Have Any Current Dental Problems? ☐ No ☐ Yes (Please List):
Has Your Student Had Problems with Dental Treatment? ☐ No ☐ Yes (Please List):
Has Your Student Had Any Injury to the Mouth or Teeth? ☐ No ☐ Yes (Please List):
Behavioral Health Services Screening Questions: Please Complete for Your Student if Requesting Behavioral Health Services **☐ Requesting Services ☐ Not Requesting Services**
Does Your Student Currently See a Behavioral Health Therapist Outside of School? ☐ No ☐ Yes (Please List):
Does Your Student Currently Work with a School Counselor? ☐ No ☐ Yes (Please List):
Does Your Student Receive IEP Counseling Provided by the School? ☐ No ☐ Yes (Please List):
Are You Concerned About Your Student's Attitude or Behaviors? ☐ No ☐ Yes (Please List):
Do You Have Any Concerns with Your Child at School: ☐Poor Academics ☐Suspensions or Detentions ☐Attention Concerns If Yes, Please Explain:

North Country Family Health Center Policies and Consents

Consent for School-Based Health Services: I authorize my student to receive services provided by the staff of North Country Family Health Center's (NoCo's) School-Based Health Program. Services may include, but are not limited to, comprehensive physical/dental examinations; treatment of illness and injury; monitoring of chronic illnesses; and behavioral health services, if needed. I consent to photographs being taken of the student for inclusion in their confidential electronic medical record for diagnosis and treatment only. I give my consent to NoCo staff to have access to the student's school health records and copies of the student's most recent physical/dental exam. I give my permission for the release of the student's medical/dental summaries including the NYS Health Examination Form and Interval Health History for Athletics Form to be shared with his/her healthcare provider and/or the school nurse to coordinate his or her care. I understand that every effort will be made to contact me prior to treatment, however, I understand this may not always be possible. The staff of NoCo believe 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/guardians to visit or call the School-Based Health Center at any time. If I have questions about enrolling my student and/or the SBHC Program, I will contact Heather Lupia, School-Based Health Services Director, at (315) 782-9450 x 8086 or Nicole Quintin, Dental Program Director, at 315-782-9450 x 8094.

Permission to Disclose to Family or Other Individuals (Non-Parents/Guardians): For patients under the age of 18 you may designate another person to attend visits and authorize treatment decisions. I understand that when I designate another person to authorize a treatment decision, North Country Family Health Center may disclose protected health information to the authorized person(s). Parents do not need to listed below.

- ☐ **No**, I do not give consent to another adult to attend, give consent for services, and/or make treatment decisions in my absence.
- ☐ **Yes**, I give consent for the following adult(s) to attend, give consent for services, and/or make treatment decisions for my child in my absence. This consent is valid for one year from the date of signature below unless revoked in writing prior to expiration. I understand that I may revoke my consent at any time.

Name of Individual(s):	Relationship to Student:

Finance Policy: North Country Family Health Center's (NoCo's) School-Based Health Program serves all students whether they are covered by insurance or not. Services provided in the school-based setting have NO out-of-pocket costs. However, if the student requires services, we do not provide within the School-Based Health Program such as outside tests or labs there may be out-of-pocket costs incurred. If you have insurance, we will bill your insurance company for you. If you do not have insurance, our partners can assist you with obtaining insurance coverage, please call our partnered Certified Application Counselor at NCPPC at 315-788-8533 ext. 228. I authorize NoCo and its representatives to release any information they obtain, including medical information, to my insurance company or their representatives to process claims for payment. As applicable, I authorize my insurance provider to pay North

Student Name: _____ Date of Birth: _____

Country Family Health Center, Inc. for services rendered.

Notice of Privacy Practices: A copy of North Country Family Health Center's (NoCo's) Notice of Privacy Practices which describes how NoCo may use and disclose my student's protected health information following applicable state and federal law is posted in the SBHC. You may also visit www.nocofamilyhealth.org for a copy.

- I understand that this may include disclosures of information to my student's insurance carrier(s) to issue payment directly to NoCo.
- I understand that I have the right to receive a copy of my student's medical/dental/behavioral health information or to request restrictions on the use of my student's protected health information.
- I understand that NoCo may engage business associates to assist in my student's coordination of care including after-hours telephone and triage coverage, Parkview Pharmacy, and call reminder service including text messages.
- I understand NoCo may use letters, reminder calls, text messages, or secure email correspondence to communicate with me regarding my student's care. I authorize NoCo to communicate with me via these methods and understand this correspondence may contain PHI.
- I understand NoCo may use computer assisted technologies guided by our internal policy & procedures to enhance my care, with all data processed securely and all clinical decisions made by a qualified healthcare provider.

Transportation Consent, Waiver, & Release: I give consent for my student to be transported by NoCo staff for the 2025-2026 school year in connection with non-emergency healthcare services and will assume all liability for my student's participation in these transportation services. I understand transportation is by appointment only. I have read, acknowledge, consent and agree to the following transportation waiver/release on behalf of my student:

- I recognize and acknowledge NoCo is neither a common carrier, nor in the business of providing transportation services to the public, and there are certain inherent risks of physical injury to vehicle passengers in the course of transportation. I knowingly, willingly, and voluntarily agree to assume any and all risk associated with my student receiving transportation services offered by NoCo, including but not limited to personal injury, illness, accidents, property loss, damages, and any other loss arising out of negligent operation or supervision of the vehicle.
- I will not hold NoCo, its officers, agents, employees, assigns, or anyone acting on its behalf, responsible or liable for injury occurring to my student in the course of such transportation services.
- I agree to waive and release all claims I may have, or which may accrue against NoCo, including its respected officers, agents, employees, assigns, or anyone acting on its behalf. I do hereby fully release and forever discharge NoCo from any and all claims for injuries, damages, or loss that my student may have or which may accrue to me or my student and arising out of, connected with, or in any way associated with said transportation services.
- My student will agree to refrain from eating, drinking, and smoking in the course of transportation services offered by NoCo.
- I understand this agreement shall be governed by the laws of the State of New York.
- I understand this Consent, Waiver, and Release for transportation is valid unless revoked in writing prior to expiration.

Consent to Release Educational Information: The information contained in your student's education records is protected by a Federal privacy law known as the Family Educational Rights and Privacy Act (FERPA). Except under limited exceptions specified in FERPA, school officials can **only** share your student's education records or discuss information from your student's records with third parties if you provide "prior written consent" that is, your explicit permission in writing.

- To provide comprehensive care to your child, North Country Family Health Center is requesting education information on your student. This may include, but is not limited to, academic performance, school health information, IEP reports, teacher reports, ADHD teacher rating scales, and/or report forms.
- I understand this consent will authorize the release of my student's education records to North Country Family Health Center for continuity of care.
- I understand this release gives your student's school district staff the authorization to speak to North Country Family Health Center staff about their academic performance.

My Signature Indicates That I Have Read and Understand the Above Information and Give My Consent as Described:

Printed Name of Legally Authorized Representative:	Relationship to Student:
Signature of Legally Authorized Representative:	Date:

North Country Family Health Center, Inc.

CONSENT FOR RELEASE OF MEDICAL AND DENTAL INFORMATION

Complete this Form if Your Student is **NOT** a Current Medical or Dental Patient of North Country Family Health Center

Student's Name:	**Student's Date of Birth:**	**Student's SS#**
Student's Address:		

I, the student's authorized representative, request that health information regarding my student's care and treatment be released as set forth on this form. I understand that with some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of HIV/AIDS-related, alcohol or drug treatment, or behavioral health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law. I have the right to revoke this authorization at any time by writing to my student's primary care provider. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization. Signing this authorization is voluntary. I understand that generally my student's treatment will not be conditional upon my authorization of this disclosure. However, I do understand that I may be denied treatment in some circumstances if I do not sign this consent.

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Complete This Section if Your Student is NOT a Current Medical Patient of North Country Family Health Center to Ensure Coordination of Care with Your Child's Primary Care Provider

My Student's Primary Care Provider's Name:

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between my student's primary care provider and my student's School-Based Health Center.

Type of Information to be Released (check all that apply):
Clinical records related to the most recent physical exam, current diagnosis, and treatment of medical issues

- ☒ All immunizations
- ☒ Past two years of lab tests, imaging, and procedures
- ☒ Past year of behavioral health treatment

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

CONSENT FOR RELEASE OF DENTAL INFORMATION

Complete This Section if Your Student is NOT a Current Dental Patient of North Country Family Health Center to Ensure Coordination of Care with Your Child's Dentist

My Student's Dentist's Name:

Name and Address of Provider of Whom this Information will be Disclosed:
North Country Family Health Center, Inc., 238 Arsenal Street, Watertown, NY 13601

Purpose of Release of Information:
Collaboration and continuity of care between your student's Dentist and your student's School-Based Dental Program.

Type of Information to be Released:
Clinical records related to the most recent dental exam, current diagnosis, and treatment of dental issues.

Unless previously revoked by me in writing, this release is effective from the date below to one year after signing.

Name of Authorized Person Signing the Form:	**Relationship to the Student:**
Signature of Authorized Person:	**Date:**