

School-Based Health Center (SBHC) Enrollment Form

What Services Do You Want to Enroll Your Student In? (Check All That Apply):		<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <input type="checkbox"/> All Services Provided at Our School-Based Site	
My Student's Information:			
Last Name:		First Name:	
Date of Birth:		Full Middle Name:	
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female		Street Address:	
Student's School:		Teacher/Homeroom:	
Biological Mother's First Name and Maiden Name:		Preferred Pharmacy Name: Address:	
Student's Primary Care Doctor's Name:		<input type="checkbox"/> My Student Doesn't Have a Regular Doctor/Healthcare Provider	
Student's Primary Dentist Name:		<input type="checkbox"/> My Student Doesn't Have a Regular Dentist	
Parent/Guardian # 1 Information:		Parent/Guardian # 2 Information:	
Name:		Name:	
Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepparent <input type="checkbox"/> Guardian (Please Provide a Copy of Court Order) <input type="checkbox"/> Other		Relationship to Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Stepparent <input type="checkbox"/> Guardian (Please Provide a Copy of Court Order) <input type="checkbox"/> Other	
Mailing Address (If Different than Student):		Mailing Address (If Different than Student):	
Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to Leave a Message/Text: <input type="checkbox"/> Yes <input type="checkbox"/> No		Best Phone Number to Reach You: _____ <input type="checkbox"/> Cell <input type="checkbox"/> Home Okay to Leave a Message/Text: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Who Does My Student Live With: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> Other:			
Who Will Make Healthcare Decisions for My Student: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Both Parents <input type="checkbox"/> Guardian <input type="checkbox"/> Stepparent <input type="checkbox"/> Other:			
Do We Have Permission to Call the Student's Emergency Contact You Provided to the School: <input type="checkbox"/> Yes <input type="checkbox"/> 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 \$ _____ <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			
Student's Ethnicity: <input type="checkbox"/> Not Hispanic, Latino/a, or Spanish <input type="checkbox"/> Mexican, Mexican American, Chicano/a <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic or Latino/a, or Spanish: _____			
Student's Race: <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Chinese <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Asian Indian <input type="checkbox"/> Other Asian: _____			
Student's Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other (Please Specify): _____			
Primary Medical Insurance		Primary Dental Insurance	
<input type="checkbox"/> My Student Has Medical Insurance <input type="checkbox"/> 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.		<input type="checkbox"/> My Student Has Dental Insurance <input type="checkbox"/> 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 #:	

Date of Birth: _____

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Student Name: _____

Date of Birth: _____

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 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

Student Name: _____

Date of Birth: _____

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: The Watertown City School District and North Country Family Health Center (NoCo) collaborate to offer K-12 students health and dental care. The Watertown City School District (WCSD) will provide transportation for students to and from appointments with NoCo when school is in session. The district provides transportation (mornings only) on an as needed basis to and from any appointments. Children at Knickerbocker, Starbuck, Sherman, or Ohio Street schools who need transportation will be provided with transport to North Elementary's School-Based Health Center (SBHC). Transportation will be provided from 8:30 a.m. to 11:00 a.m.

When students in grades K-4 have a scheduled appointment the transportation provider will go into the school to pick the child up and bring the student to the bus. He/she will transport the student to the appointment, walking him/her into the SBHC. Either he/she will escort the student back to the bus or someone from the SBHC will do so. Once the bus has returned the student to the school where he/she attends, the transportation provider will escort the student to the Main Office of that school building.

When a student in grades 5-12 must travel outside of their building but still on the main WCSD Campus, students will sign out of the building and walk to the building on Campus (Wiley, Case, or WHS) where they have their appointment. Upon returning to their building of attendance, they will sign back in. Parent permission must be on file for students to walk from one building to another on the WCSD Campus. In the event that students in grades 5-12 must travel off the WCSD Campus for the appointment, the transportation provider will wait in front of the school to pick up the student. He/she will transport the student to the appointment, walking him/her into the SBHC. Either he/she will escort the student back to the bus or someone from the SCHC will do so. The bus will drop off the student at the main entrance of the school in which he or she is in attendance. It will be the student's responsibility to check in at the Main Office of Wiley Intermediate School, Case Middle School, or Watertown High School.

I authorize the Watertown City School District to provide my child with transportation to and from any appointments they may have with the North Country Family Health Center. I understand that transportation is only provided on days when school is in session and during the morning hours, as applicable. If my child is a Watertown High School or Case Middle School student, I authorize him/her to walk from the respective building to Wiley Intermediate School for any appointments and back, signing in and out of the building as required by administration.

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:

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:		
<p>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.</p>		
CONSENT FOR RELEASE OF MEDICAL INFORMATION <i>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</i>		
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 <input checked="" type="checkbox"/> All immunizations <input checked="" type="checkbox"/> Past two years of lab tests, imaging, and procedures <input checked="" type="checkbox"/> 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 <i>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</i>		
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:	