SCHOOL-BASED HEALTH PROGRAM HEALTH QUESTIONNAIRE

FORM MUST BE COMPLETED & SIGNED EVERY YEAR

Patient Information

Student's Last Name: _____Student's First Name: _____

Today's Date: _____ Student's Grade: _____ Student's Teacher: _____

Student's Social Security Number: _____-____-_____ Student's Date of Birth: __ / ___ / _____ Gender: Male Female

Home Address: _____

Primary Phone Number: _____ Name of Parent/ Legal Guardian: _____

Parent/Legal Guardian Date of Birth: ____ / ____ / _____ Relationship to Student: _____

Can we text you with routine reminders? ☐ Yes ☐ No Number To Receive Text Messages: _____

Student's Race *you may choose more than one race: Asian White Black/African American
Native Hawaiian American Indian/Alaska Native Other Pacific Islander

Student's Ethnicity: Hispanic/Latino Not Hispanic/Latino **Language Spoken: _____**

Insurance Information

Insurance: ☐ Medicaid ☐ Commerical ☐ Medicare ☐ Uninsured Medical Insurance Company: _____

Cardholder Name: _____ Policy Number: _____ Group: _____

Secondary Insurance: ☐ Yes ☐ No If Yes, Policy Number: _____

Student's Primary Doctor Name: _____ Primary Doctor Phone Number: _____
Date of Student's Last Physical: _____ ☐ I've included a copy of my child's most recent physical

Name of Student's Pharmacy: _____ Pharmacy Address: _____

Name of Student's Dentist: _____ Date of Last Dental Appointment: _____

Emergency Contact Information

*We require the name, address and phone number of 2 contacts who can be called if you are unavailable.

Name of Contact : _____ Phone and/or Cell: _____

Alternate Number: _____ Relationship to Student: _____

Name of Contact: _____ Phone and/or Cell: _____

Alternate Number: _____ Relationship to Student: _____

BOTH SIDES OF FORMS MUST BE COMPLETE- INCOMPLETE FORMS WILL NOT BE ACCEPTED

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Medical Information

*Please list any medication that your child takes on a regular basis. (pills, sprays, inhalers, etc.)

Medication	Dosage	When do they take it	Why do they take it

Is your child taking a multivitamin: ☐ Yes ☐ No Is your child taking a fluoride supplement? ☐ Yes ☐ No

Does your child have ANY allergies: ☐ Yes ☐ No
If yes, please list and explain reaction: _____

Has your child ever been diagnosed with ANY of the following conditions: ☐ Asthma ☐ Diabetes ☐ ADHD

Does your child have ANY serious illness or medical conditions? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Has your child have ANY serious injuries or accidents? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Has your child have ANY surgery? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Has your child EVER been hospitalized overnight? ☐ Yes ☐ No
If yes, please explain and provide most recent date: _____

Does anyone in your family smoke? ☐ Yes ☐ No If yes, where: ☐ Inside ☐ Outside

Are there any health, social, or academic concerns for your child that you would like to make us aware of? ☐ Yes ☐ No

If yes, please explain: _____

** AS A REMINDER, YOU WILL NOT BE BILLED FOR ANY SERVICES THAT YOUR CHILD RECEIVES AT WYH SCHOOL-BASED HEALTH CENTER. The SBHC will bill the student's health insurance for services provided on site at the SBHC. However, services received outside the SBHC (such as lab work) are subject to fees. **

The staff of the School-Based Health Center considers parental/guardian involvement essential in keeping children healthy and will encourage each student to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time.

Parent/Guardian Signature: _____ Name: _____

Relationship to Student: _____ Date: _____

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We Welcome your Child to our School-Based Health Center!

- Please fill out the attached consent form and health questionnaire to enroll your child.
- You are always welcome and encouraged to attend appointments with your child.
- Your child can receive immunizations required for school here.
- Your child can use the SBHC for urgent care when they are sick.
- Your child can receive a physical with us *or* you can provide one from another doctor.
- Your child can have a primary doctor that is not from Whitney Young Health and still enroll in SBHC.
- We can help manage your child's health conditions such as asthma.
- We work with the school nurse; we do not replace them.
- There is never an out-of-pocket cost for SBHC services.
- Your child is enrolled as long as they attend this school or you choose to disenroll them.
- You have 24 hour access always. If school is not in session call Whitney Young Health at 518-465-4771.

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SCHOOL-BASED HEALTH PROGRAM CONSENT FOR HEALTH SERVICES

The following services will be provided to your child at the School-Based Health Center (SBHC):

1) Comprehensive physical exams, including those for school sports
2) Lab tests and screenings when necessary, to detect illness or infection (i.e., strep throat)
3) Age-appropriate immunizations
4) Assessment and treatment for acute and chronic conditions, minor injuries and emergency care
5) Health and nutrition education and counseling
6) Prescriptions and medication administration
7) Referrals to mental health services
8) Oral Health screening and fluoride varnish at participating SBHC sites
9) Referrals to outside specialists, in collaboration with PCP, for services not provided at the SBHC

I hereby give consent in my absence for **MY CHILD**, _____, to receive health care services including, but not limited to any age-appropriate care provided by the professional staff of the School-Based Health Center (SBHC).

- I further give consent to the staff of the SBHC to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare providers to share information regarding my child's treatment and you may exchange medical information as needed with the school nurse for coordination of care purposes.
- I further give consent to the staff of the SBHC to obtain copies of my child's most recent physical exam and immunization records from their Primary Care Provider.
- I further consent to the staff of the SBHC to obtain my child's medication history from external sources to be better informed about potential medication issues and use that information to improve safety and quality of care.
- I hereby give consent for my child to receive a Comprehensive Physical Exam by the professional staff of the SBHC.
- I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier for services rendered by Whitney M. Young, Jr. Health Center /SBHC Program.
- I understand and accept responsibility for costs associated with services provided outside of SBHC Program.
- I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease, and reproductive health or outpatient mental health services.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that my signature below also confirms I have received a copy of Whitney M. Young, Jr. Health Services Privacy Practices, as well as the Patient Bill of Rights and Patient Responsibilities.

The staff of the School-Based Health Center considers parental/guardian involvement essential to keeping children healthy and will encourage each student to involve their parents/guardian in health care decisions. We encourage parents/guardian to visit or call the School-Based Health Center at any time.

Signature: _____ Name: _____

Relationship to Student: _____ Date: _____

*****THIS FORM MUST BE SIGNED FOR CHILDREN TO ENROLL IN PROGRAM*****

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