

**2009-2010**  
**Student Health Center Enrollment Form**  
**Grades K-5**

**Parents** - Please complete and sign this enrollment form to give consent for your child to use the Student Health Center for one year.

Student name _____ Date of birth _____ Gender: <input type="checkbox"/> male <input type="checkbox"/> female		
School _____ Grade level _____ Student ID# _____		
Race: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Native American/Alaskan native <input type="checkbox"/> Native Hawaiian/Pacific Islander		
<input type="checkbox"/> Other race (Specify) _____ <input type="checkbox"/> Two or more races (Specify) _____		
Are you Latino or Hispanic? <input type="checkbox"/> yes <input type="checkbox"/> no      What country were you born in? _____		
What is the primary language spoken in your home? _____		
Address: _____ Home phone: _____		
Parent work phone: _____ Parent cell phone: _____ Student cell phone: _____		
Parent(s) or legal guardian(s) _____ Address (if different than above) _____		
Doctor/Health Care Provider _____ Check here if you child does not have a health care provider: <input type="checkbox"/>		

**Student Health Information**

**Please complete the following important information that will help us to know about your child's health needs:**

Doctor/Health Care Provider: \_\_\_\_\_ Check here if your child does not have a health care provider:

My child had his/her last physical exam within the last two years.  yes  no  don't know

My child will need immunizations this year.  yes  no  don't know

Significant past illnesses, injuries or hospitalizations \_\_\_\_\_

Allergies: \_\_\_\_\_ Asthma:  yes  no      Cardiac disorder:  yes  no

Other physical, dental or mental health problems: \_\_\_\_\_

Current medications: \_\_\_\_\_

**Family Health History** – Please check off where there is a family history of any of the following health conditions:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergies             | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Immune disorder  |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Heart disease       | <input type="checkbox"/> Mental illness   |
| <input type="checkbox"/> Alcohol or drug abuse | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Seizure disorder |
| <input type="checkbox"/> Cancer                | <input type="checkbox"/> High cholesterol    | <input type="checkbox"/> Tuberculosis     |

**Dental Health Information**

Does your child receive yearly dental care?  yes, at a private dentist  
 yes, at Community Dental  
 no, we need a dentist/dental care

If your child does not have a dentist or goes to Community Dental, would you like your child to get preventive dental services at school?  yes  no

Does your child have dental pain (toothache)?  yes  no

**(See back)**

**Health Insurance Information – (VERY IMPORTANT – PLEASE COMPLETE)**

Do you have Medicaid/MaineCare coverage? \_\_\_\_\_ yes \_\_\_\_\_ no    Do you have private insurance coverage? \_\_\_\_\_ yes \_\_\_\_\_ no

If employed, name of insured parent's employer \_\_\_\_\_ Check here if you have no health insurance \_\_\_\_\_.

If you have MaineCare or private insurance, please provide us with a photocopy of your insurance card or fill-in the information on the blank sample card shown below. You may also have your child bring the card to us at the health center and we will make a copy.

Title of card _____
Insured person's name _____
Policy ID or Medicaid # _____
Group # _____
Physician _____

**Consent to Use the Student Health Center**

**I give permission for my child, \_\_\_\_\_, to use the Student Health Center for one year which may include physical or dental health services.**

- \* I understand that my signature indicates that I have received and read the Student Health Center Enrollment Information.**
- \* I understand that my signature indicates that I have received a copy of the Privacy Notice.**
- \* I understand that my signature also gives permission for the Student Health Center staff to access my child's school health record and share pertinent health information between the Student Health Center staff and the school nurse or school social worker when it is deemed appropriate for treatment purposes.**
- \* I understand that my signature allows for pertinent physical and dental health information to be shared between my child's doctor or dentist when it is deemed appropriate for treatment purposes.**
- \* I understand that I may revoke this authorization at any time by written notice sent to the address below. Such revocation shall not affect any uses or disclosures permitted by your authorization while it was in effect.**

Parent/guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Please return this form to the Student Health Center or school nurse or mail/fax to:

City of Portland  
Health & Human Services Department  
Public Health Division  
166 Brackett Street  
Portland, ME 04102  
Fax 874-8477