

**2007-2008**  
**Student Health Center Enrollment Form**  
**Grades K-8**

**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: ___ male ___ female		
School _____			Grade level _____			Student ID# _____		
Race: ___ White ___ Black ___ Asian ___ Native American/Alaskan native ___ Native Hawaiian/Pacific Islander			_____			_____		
___ Other race (Specify) _____			___ Two or more races (Specify) _____			_____		
Are you Latino or Hispanic? ___ yes ___ no			What country were you born in? _____			_____		
What is the primary language spoken in your home? _____								
Social Security # _____			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: ___			_____		

**Student Health Information**

Please list below any known medical issues or special health concerns that will help us manage your child's health needs.		
Significant past illnesses, injury or hospitalizations _____		
_____		
Allergies: _____ Asthma: ___ yes ___ no Cardiac disorder: ___ yes ___ no		
Other physical, dental or mental health problems: _____		
Current medications: _____		
<b>Family Health History</b> – Please check off where there is a family history of any of the following health conditions:		
___ Allergies	___ Diabetes	___ Immune disorder
___ Asthma	___ Heart disease	___ Mental illness
___ Alcohol or drug abuse	___ High blood pressure	___ Seizure disorder
___ Cancer	___ High cholesterol	___ Tuberculosis
My child will need immunizations this year. ___ yes ___ no ___ don't know		
My child had his/her last physical exam within the last two years. ___ yes ___ no ___ don't know		
If your child is due for immunizations or a physical exam, would you like this done at school? ___ yes ___ no		

**Dental Health Information**

Your dentist's name _____		If you do not have a dentist, check here ___	
Do you need help finding a dentist? ___ yes ___ no		Does your child have dental pain (toothache)? ___ yes ___ no	
When was the last time your child went to the dentist? ___ within the last year ___ over one year ago ___ never			
If your child is due for a dental cleaning, would you like this done at school? ___ yes ___ no			

**(See back)**

**Important insurance information below – please complete**

**Health Insurance Information**

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, dental or mental health services.**

- \* I understand that my signature indicates that I have received a copy of the Notice of Privacy Practices.**
- \* 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 with the school nurse or school social worker when it is deemed appropriate for treatment purposes.**
- \* I understand that my signature allows for pertinent health and dental health information to be shared with my child's doctor or dentist and with the mental health personnel from Community Counseling Center when and if my child is accessing those services.**
- \* 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  
134 Congress Street  
Portland, ME 04101  
Fax 874-8920**