Foothill Community Health Center

Student Health & Wellness Program Enrollment Form

STUDENT INFORMATION

FIRST NAME:	LAST NAME:	GRADE:
NAME OF SCHOOL:	DATE OF BIRTH:	GENDER: MALE ☐ FEMALE ☐

RACE (circle): Black/African American White Asian Native Hawaiian American Indian/Alaskan Native More than one race Other Pacific Islander Decline to report Other: ________________________________

Ethnicity (circle): Hispanic or Latino NOT HISPANIC OR LATINO Decline to report Other: ______________________

PARENT (s) OR GUARDIAN INFORMATION

Name:	DOB:	Name:	DOB:
Address:		Address:	
City: Zip:		City: Zip:	
Home Phone: Cell:		Home Phone: Cell:	
Relationship to child (circle): Mother Father Guardian		**Relationship to child (circle): Mother Father Guardian**	

Preferred Langauge (circle): English Spanish Vietnamese Other__________________

INSURANCE INFORMATION

Does your child have health insurance? Yes ☐ No ☐

Insurance Name	**Policy Number:**

*** If NO, are you interested in enrolling your child into a public health insurance program? Yes ☐ No ☐**

Household Annual Income: ☐ $0 - $15,856 ☐ $15, 857 - $21, 404 ☐ $21,405 - $26,951 ☐ $26,952 - $32,499 ☐ $32,500 -$38,047 ☐ over $38,047	**Family Size (# of people in household): ___________**

HEALTH ALERTS

Is your child being treated for any health issues?	☐ YES	☐ NO
If yes, please explain:		
Does your child have any known allergies to food, medications, or any vaccines?	☐ YES	☐ NO
If yes, please explain:		
Has your child had any serious reactions after receiving vaccinations in the past?	☐ YES	☐ NO
Has your child had seizures, nervous system problems, or history of Guillain Barre syndrome	☐ YES	☐ NO

PARENTAL CONSENT FOR TREATMENT

I/We have read and understand the services provided by Foothill Community Health Center as described below.
I/We understand further that the services authorized by my/our signature on this form are and not limited to:

**** Sport Physicals and/or Annual Exams (CHDP)***
**** Tuberculosis Screening and Testing***
**** Dental Screenings & Treatment***
**** Diagnosis and treatment of minor illnesses and First Aid***
**** Immunizations (ALL REQUIRED school vaccines, flu shots, etc.)***
**** Health Education and Nutrition Counseling***
**** Behavioral Health Counseling***
**** Optometry Services and Referrals***
**** Short-term assistance with chronic illness management & referrals***

- I UNDERSTAND MY CHILD **WILL NOT** BE CHARGED DIRECTLY FOR SERVICES DELIVERED AT THE HEALTH CENTER.
- I/WE understand that this consent covers only those services provided at this clinic, and does not authorize services rendered at any other private or public facility that are not affiliated with Foothill Community Health Center
- I realize that the Health Center staff will coordinate with the student's primary care provider to ensure continuity of care and will refer ongoing care needs to the student's regular physician
- I/We understand that this consent form remains in effect until my enrollment at my child's school terminates, or until revoked in writing.

This student has my/our permission to receive all services provided by Foothill Community Health Center **EXCEPT those which I have specifically excluded as follows:** ____

Print Name of Parent or Guardian:	
Signature of Parent or Guardian:	**Date:**

Forms are available in Spanish or Vietnamese at your child's school administration office or contact us at:
Las formas están disponibles en ingles y vietnamese en la oficina de administración de la escuela de su hijo o comuníquese con nosotros al:
Các đơn bằng tiếng anh và tiếng tây ban nha đã có sẵn tại văn phòng trường học của con quý vị hay liên lạc chúng tôi tại:

(408)755-3904

Rev.10/20/15

2680 South White Road, Suite 150 San Jose, CA 95148
Phone (408) 755-3904 Fax (408)775-7050

MEDICAL RELEASE FORM

Medical records will be kept confidential. However, I/We acknowledge that the services for my child's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School-Based Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing her/him

I hereby authorize the School-Based Health Center staff and provider to exchange information concerning my child for the purpose of medical evaluation and treatment. I understand this consent will not expire until I revoke it or my child/ward is no longer enrolled in a school served by Foothill Community Health Center (School-Based Health Center.)

____

Student's Full Name

____

Print Name of Parent/Legal Guardian

____

Signature Parent/Legal Guardian   Date

____

Address of Parent/Legal Guardian (if different from student)