UCFS Norwich Technical School Based Health Center Enrollment Form

United Community & Family Services

Client ID#

The UCFS School Based Health Center at Norwich Tech offers the following services:

Medical - Physicals, Preventive Care, Immunizations, Treatment of Minor Injuries and Illness, Reproductive Health and Health Education

Behavioral Health - Mental Health Assessments, Substance Abuse Screenings, Counseling (individual, group and family)

Dental Health - Dental Hygiene Cleanings, Preventive Care (specific times of the year by appointment only)

Who Can Receive Services? Only Norwich Technical High School students can receive services at the School Based Health Center. It is not open to the public.

Why Enroll Your Child? Students receive the care they need on premesis during the school day without missing class. Parents do not need to miss work to take their child to appointments. UCFS School Based Health Center collaborates and communicates with your child's primary care provider.

How Do I Enroll My Child? To enroll your child in school based services, please complete all attached forms in pen and return to the Norwich Techinical High School Main Office. Forms can also be mailed to: UCFS c/o Norwich Technical High School, 7 Mahan Drive, Norwich, CT 06360. Additional forms can be found at www.ucfs.org or at the UCFS School Based Health Center at Norwich Tech (Room 103 and Resource Room).

Cost: Insurance is billed whenever possible in order to sustain the UCFS School Based Health Center. However, students will receive care regardless of the ability to pay.

For any questions or to request more information please email Nancy Holte, RN at nholte@ucfs.org or call 860-892-7042

Client Information

Name:			
Address:		City/Sate:	
Phone (Home):	(Cell):	Zip:	
Email:			
UCFS may leave messages with medical results (check one): ☐ Home ☐ Cell ☐ None			
Birthdate: / /	Gender: ☐ M ☐ F	SS#	
Preferred Language: ☐ English ☐ Spanish ☐ Other:			

Race	Please Check all that Apply.	
Asian	☐	(A)
American Indian or Alaska Native	☐	(G)
Black or African American	☐	(B)
Native Hawaiian	☐	(J)
Other Pacific Islander	☐	(P)
White	☐	(W)
Other	☐	(E)

How many people are in your household?	Estimated Household Income $ weekly / bi-weekly / monthly
Has your child been homeless at any time during the last 12 months? ☐ No ☐ Yes If yes, please indicate when:	
Is the student now, or have they ever been a UCFS Patient? ☐ No ☐ Yes If yes, please check all that apply ☐ Medical ☐ Dental ☐ Behavioral Health	
Student's Primary Care Provider: Name:	Phone Number:
Student's Dental Provider: Name:	Phone Number:
Student's Behavioral Health Provider: Name:	Phone Number:
Where else does your child receive services? ☐ Emergency Room ☐ Walk-in/Urgent Care Clinic ☐ Military Clinic	
Name of Pharmacy:	City:

Associated Parties

Please indicate persons other than yourself who UCFS may contact for the following purposes (check all that apply):

Name	DOB	Relationship to Client	Phone Number	Emergency Contact	Discuss appointment information	Discuss billing information	Discuss Treatment Received	If minor, may bring to appointments
Example: Brian Fake Client	1/1/1900	Father	(860) 123-4567	☒	☐	☐	☒	☒
				☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐

By signing below, I authorize UCFS to communicate with the Associated Parties listed above as indicated.

I understand that it is my responsibility to update UCFS with changes to the Associated Parties listed above. The information I have provided above will remain active and in effect until such time new information is provided to UCFS.

Printed Name

Signature of Cient, Parent or Legal Guardian **Date**

Student Name_____ Date of Birth_____

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Consent for Services

Student Name: | Date of Birth:

Consent: Please check Y or N after each statement and sign at the bottom. By signing below, I understand and acknowledge I have read and understand this consent.	Y	N
I give permission for my child to receive the following services at the UCFS School Based Health Center. I certify that the health information provided is accurate to the best of my knowledge. I understand that providing incorrect information may be dangerous to the student/patient's health. I will contact school-based staff if my/my child's health history changes:	☐	☐
Medical Services	☐	☐
Behavioral Health Services (therapy)	☐	☐
Smiles on the Move Mobile Dental	☐	☐
Dental - I give permission for my child to be treated and receive services deemed necessary by the staff at United Community & Family Services, Inc. ("UCFS"), including dental cleanings, fluoride treatments, examinations, sealants and x-rays if dental is a selected service.	☐	☐
Dental - I understand that my child will receive all eligible dental services, including sealants.	☐	☐
Dental - I understand I am responsible to pay for the services rendered if I do not have insurance. A total of $40 will be charged which includes exam, cleaning, fluoride and xrays.	☐	☐
Release of Information and Payment Authorization		
I authorize the release of any medical or other information necessary to process my claim. I also authorize payment of medical benefits to UCFS for services provided.	☐	☐
Authorization for Exchange of Health and Education Information:		
I hereby authorize UCFS to exchange health and education records with my child's school district for the purpose of providing dental care and treatment to my child.	☐	☐
Consent and Acknowledgement of Privacy Practices:		
I consent to the use or disclosure of my protected health information by UCFS to any person or organization for the purposes of carrying out treatment, obtaining payment, or conducting certain healthcare operations. Protected health information used or disclosed by UCFS may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how UCFS will use and disclose my information can be found in UCFS' Notice of Privacy Practices. I understand that this consent is effective for as long as UCFS maintains my protected health information.	☐	☐
I acknowledge that I have received the UCFS Patient Rights and Responsibility Policy	☐	☐

_____

Signature of Cient, Parent or Legal Guardian

_____

Date:

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Health History

Student Name:	Date of Birth:

Does your child have any of the following conditions?

ADD/ADHD	☐	Yes	☐	No	Heart Disease/Problems	☐	Yes	☐ No
Anemia	☐	Yes	☐	No	Hypertension	☐	Yes	☐ No
Asthma	☐	Yes	☐	No	Immune Disorder	☐	Yes	☐ No
Birth Defects	☐	Yes	☐	No	Learning Difficulties	☐	Yes	☐ No
Bipolar	☐	Yes	☐	No	Mental Illness	☐	Yes	☐ No
Cancer	☐	Yes	☐	No	Overweight	☐	Yes	☐ No
Diabetes	☐	Yes	☐	No	Seizures	☐	Yes	☐ No
Dental Problems	☐	Yes	☐	No	Sleeping Problems	☐	Yes	☐ No
Depression	☐	Yes	☐	No	Substance Abuse (alcohol or drugs)	☐	Yes	☐ No
Eczema	☐	Yes	☐	No	Tobacco Use	☐	Yes	☐ No
HIV/AIDS	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐ No
Head Injury	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐ No
Hearing Problems	☐	Yes	☐	No	Weight Loss	☐	Yes	☐ No
High Blood Pressure	☐	Yes	☐	No	Other Conditions/Concerns:			

Has your child been in the hospital overnight?	☐	Yes	☐	No	When:	Why:
Has your child had surgery?	☐	Yes	☐	No	When:	Why:
Has your child been in a serious accident?	☐	Yes	☐	No	When:	Why:
Does your child take any medicines?	☐	Yes	☐	No	Name of Medicine:	
Does your child take any vitamins or supplements?	☐	Yes	☐	No	Please list:	
Is your child allergic to any medicine?	☐	Yes	☐	No	Name of medicine:	
Is your child allergic to food or other things?	☐	Yes	☐	No	Name of food/other:	
Has your child had chicken pox?	☐	Yes	☐	No	At what age?	
Is your child receiving any counseling at this time?	☐	Yes	☐	No	Where?	
Has your child been in counseling in the past?	☐	Yes	☐	No	Where?	

If female, is the student:

Nursing?	☐	Yes	☐	No	Pregnant or possibly pregnant?	☐	Yes	☐ No
Having Menstrual Problems?	☐	Yes	☐	No	Taking birth control pills?	☐	Yes	☐ No

For dental services, does the student:

Have special mobility needs?	☐	Yes	☐	No	Have any needs the hygienist should know before treating the student?	☐	Yes	☐ No
Have experience seeing a dentist?	☐	Yes	☐	No	Have gums that bleed while brushing or flossing?	☐	Yes	☐ No
Require pre-medication before dental treatment?	☐	Yes	☐	No	Have teeth causing him/her pain?	☐	Yes	☐ No

FAMILY HISTORY: Does anyone in the child's family have the following conditions? (Mother, Father, Sibling, Grandparent)

				Family Member					Family Member
ADD/ADHD	☐	Yes	☐	No	Heart Disease	☐	Yes	☐	No
Anemia	☐	Yes	☐	No	Hypertension	☐	Yes	☐	No
Asthma	☐	Yes	☐	No	Immune Disorder	☐	Yes	☐	No
Birth Defects	☐	Yes	☐	No	Learning Difficulties	☐	Yes	☐	No
Bipolar	☐	Yes	☐	No	Overweight	☐	Yes	☐	No
Cancer	☐	Yes	☐	No	Seizures	☐	Yes	☐	No
Diabetes	☐	Yes	☐	No	Substance Abuse	☐	Yes	☐	No
Dental Problems	☐	Yes	☐	No	Tobacco Use	☐	Yes	☐	No
Depression	☐	Yes	☐	No	Thyroid Disease	☐	Yes	☐	No
Eczema	☐	Yes	☐	No	Tuberculosis	☐	Yes	☐	No
Head Injury	☐	Yes	☐	No	Menstrual Problems	☐	Yes	☐	No

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Insurance Information

Student Name:	Date of Birth:

Type of Insurance (check all that apply and complete information below on your child's insurance coverage)

☐ Medicaid (Title 19) ☐ Private/Commercial Insurance ☐ Dental

☐ No Insurance ☐ I am interested in insurance eligibility screening, please have someone contact me

Primary Insurance Information:

Policy Holder's Name: _____ Relationship to Student: _____

Policy Holder's Address: _____ Policy Holder's DOB _____

Policy Holder's Social Security Number: _____

Insurance Carriers Name and Phone Number: _____

Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____

Effective Date of Coverage: _____

Policy Holder's Employer Name _____

Dental Insurance Information:

Policy Holder's Name: _____ Relationship to Student: _____

Policy Holder's Address: _____ Policy Holder's DOB _____

Policy Holder's Social Security Number: _____

Insurance Carriers Name and Phone Number: _____

Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____

Effective Date of Coverage: _____

Policy Holder's Employer Name _____

Other Insurance Information:

Policy Holder's Name: _____ Relationship to Student: _____

Policy Holder's Address: _____ Policy Holder's DOB _____

Policy Holder's Social Security Number: _____

Insurance Carriers Name and Phone Number: _____

Policy #: _____ Group #: _____ Group Name: _____ Plan #: _____

Effective Date of Coverage: _____

Policy Holder's Employer Name _____