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? Expalin:	☐ YES	☐ NO
Does your child have any known allergies to food, medications, or any vaccines?Explain:	☐ YES	☐ NO
Has your child had seizures, nervous system problems, or history of Guillain Barre syndrome	☐ YES	☐ NO
Has your child had any serious reactions after receiving vaccinations in the past?	☐ YES	☐ NO

When was your child's last medical exam?	Primary Care Provider Name & Ph#:
When was your child's last dental exam?	Dentist Name & Ph#:

PARENTAL CONSENT FOR TREATMENT

I/We have read and understand the servicesoffered at the Foothill Community Health Center School-Based 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)***
****Chronic Disease Management (i.e. diabetes, asthma)***
****Optometry Services & Referrals***
**** Diagnosis and treatment of minor illnesses/injuries***
**** Immunizations (ALL REQUIRED school vaccines, flu shots, etc.)***
****Tuberculosis Screening and Testing***
****Dental Screenings and Treatment***
****Behavioral Health Counseling***

• I/We understand that my child **WILL NOT** be charged directly for services provided by FCHC based on household income and/or insurance eligibility.

• I/WE understand that FCHC **will bill my child's health insurance plan** for all services that are eligible for reimbursement. If my child is uninsured or has limited coverage, FCHC will attempt to enroll my child into a health coverage program.

• I/We understand if my child is uninsured and/or has limited health coverage, FCHC will offer **FREE** health coverage enrollment assistance. If I/we decline seeking health coverage enrollment assistance, I/we may be financially responsible for my child's services provided by FCHC and **NOT** covered under the SHWP.

• I/We understand that this consent covers only services provided by FCHC providers and services are at **NO-COST** for **eligible students** enrolled into SHWP .

•I/We realize that FCHC staff will coordinate and refer my child's on-going health care needs to his/her primary care provider to ensure continuity of care.

• I/We understand that this consent form remains in effect until my child's enrollment at 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:**

Foothill Community Health Center
2880 Story Road, San Jose, CA 95127
Phone (408) 729-9700

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 Foothill Community 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 in writing 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)