KENNEDY COMMUNITY HEALTH SCHOOL-BASED HEALTH CENTER ENROLLMENT FORM

Please notify the school if there are any changes in your child's medical history or medications during the year.

Patient's Name (first) ______________________________(last)________________________________

Date of Birth: _____/_____/________ Sex Assigned at Birth : ☐ Male ☐ Female

Address: ____

Phone Number: _________________________ Email address: ___________________________________

School: ________________________________ Preferred language at home _________________________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race (you can specify more than one):

☐ American Indian/Alaska Native ☐ Asian ☐ White ☐ Black ☐ Native Hawaiian/Pacific Islander

☐ Unknown/Not Specified ☐ Other (specify): __________ ☐ Prefer not to answer

Health Information:

1. Does your child see a dentist for biannual checkups? ☐ YES ☐ NO
2. Does your child have a primary care provider (PCP)? ☐ YES ☐ NO
3. Is your child taking any medication now? If yes, please list: ________________________________
4. Please circle any conditions your child has EVER had:

   Diabetes Hepatitis Epilepsy/Seizures Kidney/Liver Disease Cancer Asthma HIV/AIDS

   Tuberculosis Immune Disorders Heart Conditions Autism/Developmental Disability Blood Disorders/Anemia
5. Does your child have any other health conditions? If yes, please list: ____________________________
6. Does your child have any allergies? If yes, please list: _______________________________________

I understand that these services are available to my child as needed and are extension of but not a replacement for my child's existing providers. I give consent for my child to receive health services at any of the school-based health centers offered by Edward M. Kennedy Community Health Center (Kennedy Community Health). I authorize a health practitioner to provide physical, dental and behavioral health services for my child in person or through a secure telehealth platform. I give permission for necessary medical tests, evaluations, and management of my child's health care. I authorize the dental provider to perform any and all forms of treatment including dental cleaning, fluoride, sealants, diagnostics, and x-rays, that may be indicated and/or available. I have read and understand the dental program and I consent to have my child participate in the dental program.

I also consent to the exchange of health and demographic information between the school health center providers, school nurse, school adjustment counselor, and any other medical professionals that may be needed, either verbally or through the school's student information system. I understand that my child's health record will be securely maintained by Kennedy Community Health as a confidential medical record; it is not a school record. I also understand that confidentiality will be observed between the staff and any child using the school-based health center.

The school-based health centers take part in the Massachusetts Immunization Information System (MIIS). MIIS is a confidential statewide system to keep track of immunization records for children and adults. To limit who can see your child's information, you need to fill out the 'Objection or Withdrawal of Objection to Data Sharing" form, which you can get from your healthcare provider.

I further authorize Kennedy Health Center to release information regarding treatment to third party payers or others for billing purposes and for any reason that may be required to comply with statues, laws or regulations in accordance with accepted medical practice. I have the opportunity to review a copy of the HIPAA privacy notice. I have read and completed this consent form and understand that this consent form will be in effect as long as my child is enrolled at a school affiliated with Kennedy Community Health unless I notify the school health center in writing.

☐ **PLEASE CHECK IF YOU WANT YOUR CHILD TO RECEIVE DENTAL SERVICES.**

☐ **PLEASE CHECK IF YOU WANT YOUR CHILD TO RECEIVE MEDICAL SERVICES.**

____

Parent/Guardian Signature **Print Name/Relationship to Patient** **Date**

Kennedy Community Health School-Based Health Center

INSURANCE INFORMATION

THE SCHOOL-BASED HEALTH CENTER DOES NOT COLLECT CO-PAYS AND PROVIDES CARE REGARDLESS OF ABILITY TO PAY.

Medical Insurance

Please complete A, B **OR** C to the best of your ability.

A. ☐ Private Insurance Company: ______________________________

Policy #: ______________________ Group ID #: ______________________

B. ☐ MassHealth/Medicaid: ID #: ______________________________

C. ☐ No Insurance Would you like assistance with insurance enrollment? ☐ YES ☐ NO

Dental Insurance

Please complete A, B **OR** C to the best of your ability.

A. ☐ Private Insurance Company: ______________________________

Address: ______________________________

Subscriber: ______________________________

Subscriber Number: ______________________________

Subscriber Date of Birth: ______________________________

Policy/Group #: ______________________________

Employer Name: ______________________________

B. ☐ MassHealth/Medicaid: ID #: ______________________________

C. ☐ No Insurance Would you like assistance with insurance enrollment? ☐ YES ☐ NO

We need to collect the following information for compliance purposes. Thank you.

Head of Household Information:

Name: ______________________________

Number of individuals in household: __________

Household Income $________________/ Biweekly

PLEASE BE SURE TO SIGN THE OTHER SIDE OF THIS FORM BEFORE SUBMITTING

FOR QUESTIONS REGARDING THE SCHOOL-BASED HEALTH CENTERS, PLEASE CALL 508-595-1102.

WE HELP PEOPLE LIVE HEALTHIER LIVES.

SCAN HERE

for Privacy Notice
kennedychc.org/SBHC