

Connecticut Institute for Communities, Inc. (CIFIC) Greater Danbury Community Health Center (GDCHC)

School Based Health Centers Permission Form

All information on the front and back of this permission form must be completed, dated and signed before your child can receive services from the School Based Health Centers. If a student is 18 or older, he/she may sign his or her own permission form. *Race /* Ethnicity information is required by the State and will be used for statistical purposes only.

| | | | |
|--|--------------------------------|---|---------------|
| Student Name (Last, First, M.I.) | Date of Birth (month/day/year) | <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ | Grade/Cluster |
| Street Address (Street, Town, State, ZIP code) | | Student's Cell Number | |

| | | |
|--|-------------------------|--------------------------------|
| Parent/Guardian Name | Relationship to Student | Date of Birth |
| Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code) | | Parent/Guardian E-Mail address |
| Home Phone Number | Cell Phone Number | Work Phone Number |

| | | |
|--|-------------------------|--------------------------------|
| Parent/Guardian Name | Relationship to Student | Date of Birth |
| Parent/Guardian Address, if different from the student (Street, Town, State, ZIP code) | | Parent/Guardian E-Mail address |
| Home Phone Number | Cell Phone Number | Work Phone Number |

| | |
|-------------------------------|-------------------------|
| Emergency Contact Name | Relationship to Student |
| Home Phone Number | Cell Phone Number |
| | Work Phone Number |

| | |
|---|---|
| *Race: (Please check one) <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported / Refuse to Report | In what country was the student born? |
| *Ethnicity: Hispanic/Latino? <input type="checkbox"/> YES or <input type="checkbox"/> NO What language(s) does the student speak? (<i>check all that apply</i>) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Portuguese <input type="checkbox"/> Other: _____ | Translator needed: <input type="checkbox"/> YES or <input type="checkbox"/> NO |
| Is the student on the free or reduced lunch program? <input type="checkbox"/> YES or <input type="checkbox"/> NO | Estimated Family Income \$: _____ # of Family Members: _____ |

| | |
|---|---|
| Medical Care | Dental Care |
| Name of Doctor or Medical Clinic: <i>If No doctor, write "NONE" below</i> | Name of Dentist: <i>If No Dentist, write "NONE" below</i> |
| Doctor's Address (Street, Town, State, ZIP) | Dentist's Address (Street, Town, State, ZIP) |
| Doctor's Phone Number: _____ | Date of last physical exam: _____ |
| | Dentist's Phone Number: _____ |
| | Date of last dental exam: _____ |

Pharmacy Name: _____ **Address:** _____ **Phone #:** _____

| | |
|--|--|
| <p>Does the student have MEDICAID/Husky Insurance: YES or NO Medicaid Pending: YES or NO **Please provide a copy of the insurance card</p> <p>If your child does not have health insurance Please call 1-877-CT-HUSKY</p> <p>Medicaid #: _____</p> <p>Child's name on Card: _____</p> <p>*If NO insurance, contact the SBHC for enrollment Assistance</p> | <p>Does the student have Private/Commercial Insurance: YES or NO **Please provide a copy of the insurance card</p> <p>Name of Insurance Company: _____</p> <p>Policy Holders Name: _____</p> <p>Policy Holders Date of Birth: _____</p> <p>Policy Holders Address: _____</p> <p>Policy Holders Employer: _____</p> <p>Relationship to student: _____</p> <p>Insurance Number for the student: _____</p> <p>Group number: _____</p> |
|--|--|

Newtown Middle School SBHC (7:30am – 2:30 pm) Phone: (203) 270-6114 Fax: (203) 270-4644

SBHC Medical History Form (Page 2)

Student's Name: _____

Date of birth: _____

Is the student currently taking any medications? Yes No **If YES, please list below including dosages and how often.
(Include asthma inhalers and EpiPens)**

Medical History:

Please check all that apply and explain on the lines below:

- | | | |
|---|--|--|
| <input type="checkbox"/> Hospitalization or Surgery | <input type="checkbox"/> Fainting or Blacking-Out | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Allergies (food, medication, bees, etc.) | <input type="checkbox"/> Running / Exercise Problems | <input type="checkbox"/> History of Seizures |
| <input type="checkbox"/> Seasonal / Environmental Allergies | <input type="checkbox"/> Asthma / Breathing Issues | <input type="checkbox"/> Headaches / Migraines |
| <input type="checkbox"/> Broken bones, Dislocations | <input type="checkbox"/> Blood Disorders /Anemia / Sickle Cell | <input type="checkbox"/> Diabetes/Thyroid/Endocrine |
| <input type="checkbox"/> Muscle or Joint Injuries | <input type="checkbox"/> Vision Problems (Contacts / Glasses) | <input type="checkbox"/> Weight or Eating Issues |
| <input type="checkbox"/> Neck or Back Injuries | <input type="checkbox"/> "Mono" | <input type="checkbox"/> Females: Menstrual problems |
| <input type="checkbox"/> Heart Defects / Murmurs | <input type="checkbox"/> TB or Positive Skin Test | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> High Blood Pressure / Cholesterol | <input type="checkbox"/> Skin Problems (Eczema, Psoriasis) | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Chest Pain during or after exercise | <input type="checkbox"/> Dental Problems (Pain / Bleeding) | <input type="checkbox"/> Any other medical problems |

Is the student under the care of any medical specialist? Yes No

Has student seen a dentist within the last year? Yes No Has student seen same dentist for more than one year? Yes No

Mental Health History:

Please check all that apply and explain on the lines below:

- | | |
|--|---|
| <input type="checkbox"/> Mood Disorder / Depression | <input type="checkbox"/> Learning Disorder / ADD / ADHD / Autism Spectrum |
| <input type="checkbox"/> Anxiety / Panic / OCD | <input type="checkbox"/> Loss / Divorce / Deportation of family members |
| <input type="checkbox"/> Anger / Other Behavioral Issues | <input type="checkbox"/> Substance use / Vaping |
| <input type="checkbox"/> Academic Concerns | <input type="checkbox"/> Eating / Significant Weight loss or gain |
| <input type="checkbox"/> Cutting / Self-harm | <input type="checkbox"/> Other unlisted concerns |

Family History:

Please check all that apply and explain which family members they apply too on the lines below:

- | | |
|--|--|
| <input type="checkbox"/> Family member with heart disease | <input type="checkbox"/> Family member with mental illness (i.e. depression) |
| <input type="checkbox"/> Family member with high cholesterol | <input type="checkbox"/> Family members with alcohol / drug problems |
| <input type="checkbox"/> Family member with diabetes | <input type="checkbox"/> Family medical problems not addressed above |
- Has any sudden family member died of heart problems or sudden death before age 50?** Yes No

PLEASE SPECIFY WHICH FAMILY MEMBER (Maternal / Paternal): _____

This medical history is accurate to the best of my knowledge. I understand that I am required to inform the School Based Health Center if there are any changes in my child's mental or physical health.

I have read the information regarding the CIFC GDCHC School Based Health Center and I give permission for this student to obtain all services offered at the School Based Health Center while he/she is enrolled in school. I understand that services are confidential, except in life-threatening situation or emergency services and accordance with the law. I give permission to the CIFC GDCHC School Based Health Centers and the Newtown Public Schools to exchange pertinent information to appropriate persons for the purpose of providing healthcare, diagnosis, treatment and counseling services, as well as maintaining safety in schools. This shared information may include health, academic and special education data needed for treatment/services to the named insurance providers for the purpose of billing. I authorize payments to be made directly to the CIFC GDCHC School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the CIFC GDCHC's privacy policy as per federal law. Unless I choose to withdraw my consent in writing, this authorization for services at the School Based Health Centers will continue for the entire period of time this student is enrolled in Newtown Public Schools.

Date: _____ **Signature:** _____ **Relationship to student:** _____

**Connecticut Institute For Communities, Inc. (CIFIC)
Greater Danbury Community Health Center (GDCHC) NOTICE OF PRIVACY
PRACTICES**

THIS NOTICE DESCRIBES HOW THE GREATER DANBURY COMMUNITY HEALTH CENTER (“GDCHC”) MAY USE AND/OR DISCLOSE HEALTH INFORMATION ABOUT YOU, HOW YOU CAN ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

GDCHC’s Commitment to Your Privacy

GDCHC is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this Notice of our legal duties and the privacy practices that we maintain at GDCHC concerning your PHI. According to federal and state law, we must follow the terms of the Privacy Notice that we have in effect at the time. This Notice will take effect on August 1, 2013, and will remain in effect until it is amended or replaced by GDCHC.

GDCHC reserves the right to change its privacy practices as the law permits. GDCHC will amend this Notice to reflect any change(s) and make any new Notices available upon request. Any changes to our privacy practices will be effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of GDCHC’s Notice of Privacy Practices at any time by contacting our Privacy & Security Officer, Diana Trumbley, at (203) 743-0100, or via mail at 57 North St., Suite 311, Danbury, CT 06810. You may also contact Ms. Trumbley with questions about this notice or to file a privacy/security complaint.

GDCHC WILL KEEP YOUR HEALTH INFORMATION CONFIDENTIAL, USING IT ONLY FOR THE FOLLOWING PURPOSES. PLEASE NOTE THAT THE FOLLOWING USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Treatment: While we are providing you with health care services, we may share your protected health information (PHI), including electronic protected health information (ePHI), with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, or data analysis. These business associates and subcontractors are required by Federal law to protect your health information. For example, we may ask you to have laboratory tests (such as blood or urine), and we may use the results to help us reach a diagnosis. We may use your PHI in order to write a prescription for you, or we may disclose your PHI to a pharmacy when we order a prescription for you. We have established “minimum necessary” or “need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Additionally, everyone on our staff is required to sign a confidentiality statement.

Payment: We may use and disclose your PHI to seek payment for services we provide to you. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatments. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Healthcare Operations: We may use and disclose your PHI to operate our business. For example, we may use your PHI to evaluate the quality of care you received from us, to evaluate the implementation of our compliance programs, and/or to conduct cost-management or business planning activities.

Abuse or Neglect: We may disclose your PHI to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

NOTE: This is an abbreviated version of GDCHC’s Notice of Privacy Practices. The full notice lists: (1) additional ways GDCHC may use your health information; (2) situations when your authorization is required for release; and (3) your rights regarding PHI. A full notice is available at all GDCHC sites. To receive a copy of the full and complete GDCHC Notice of Privacy Practices, please contact School Based Health Center Staff. Rev. 4/2014