FRANKLIN PRIMARY HEALTH CENTER INC

School-Based Health Center
Consent & Enrollment Form

Child Information:

Child Name: _____ Child SS#_____
Date of Birth: ___/____/_____ Gender: _____
Race (black, white, etc.): _____
Ethnicity (Non-Hispanic, Mexican, etc.): _____
Language: _____
Homeless Status (please circle): Not Homeless Homeless Living in Shelter
Living with Others At Risk of homeless Other: _____
Grade: _____ Phone#: (__)_____
Address: _____ City: _____
State: _____ Zip: _____ Email Address: _____

Parent/Guardian Information:

Name: _____ Relationship to Child: _____
Phone #: (___)_____ Alternate #: (___)_____
Email Address: _____

Emergency Contact Information:

Name: _____ Relationship to Child: _____
Phone #: (__)_____ Alternate #: (___)_____

Child's Insurance Information:

Primary Health Insurance:
Name of insured parent/guardian: _____
Address (if different from child): _____
Date of birth of insured cardholder: _____
Place of employment: _____
Name of insurance company: _____
Insurance phone/fax number: _____
Group & ID number: _____

Secondary Health Insurance:
Name of insured parent/guardian: _____
Address (if different from child): _____
Date of birth of insured cardholder: _____
Place of employment: _____
Name of insurance company: _____
Insurance phone/fax number: _____
Group & ID number: _____

Person responsible for bill: _____ DOB: _____
If no insurance, household size: _____ Annual income: _____

(Needed for sliding fee scale discount.)

Health Information:

1. Does your child currently have or have a history of the following problems?
    - Allergies to food, medications, or other? _____
    - Asthma
    - Birth problems
    - Blood clots/strokes
    - Cancer
    - Chicken pox
    - Developmental delays
    - Diabetes
    - Headaches
    - Heart disease
    - High blood pressure
    - High cholesterol
    - Mental illness _____
    - Seizures
    - Sickle cell anemia
    - Substance abuse (drugs or alcohol) _____
    - Tuberculosis
    - Other _____

1. Has your child had any minor or major surgeries? If yes, please explain.
   _____
   _____
2. Has your child been hospitalized for anything? If yes, please explain.
   _____
   _____
3. Does your child take any medications? If yes, please list.
   _____
   _____
   _____
4. Pediatrician name/phone number
   _____
5. Date of last well child visit _____

6. Dentist name/phone number _____
7. Last dental exam _____
8. Optometrist name/phone number _____
9. Date of last eye exam _____
10. What pharmacy does your child use (name and phone number)?
    _____
    _____

Family History:

Does anyone in your family (mother, father, siblings, and grandparents) currently have or have a history of the following problems?

Condition	Who?	Maternal or Paternal side?
• Asthma		
• Blood clots/stroke		
• Diabetes		
• Heart disease		
• High blood pressure		
• High cholesterol		
• Mental illness		
• Sickle cell anemia		
• Substance abuse (drugs or alcohol		
• Tuberculosis		
• Other _____		

I give consent for the child named above, to receive services from the Franklin Primary Health Center School Based Health Center. Services may include the following: well-child physicals, sport physicals, diagnosis and treatment for acute and chronic conditions, vision, dental, minor injuries, immunizations, health coaching, prescriptions, behavioral/mental health counseling, classroom presentations (as assigned), and referral for services which cannot be provided at FPHC SBHC.

Franklin's patient rights and responsibilities, notice of privacy practices and grievance polices have been explained to me and I have received a copy. I have also been informed that if I have a complaint or experience any problems during my visit to ask for the office manager. Initials _____

Assignment and release: I, the undersigned certify that the above information is true and correct. I consent to any services rendered to my child under doctor's orders. I authorize payment of healthcare benefits to FPHC, Inc. I understand that I am financially responsible for all charges and reference lab fees not paid by insurance. I hereby authorize FPHC, Inc., to release all information necessary to secure payment of benefits.

I understand that this consent form will be valid until my child leaves/graduates from FPHC SBHC. I may revoke this consent form at any time.

I have read the above information and have had the opportunity to have any of my questions answered.

_____ _____

Signature of Parent/Legal Guardian Date