Registration # _____

Danbury Health Department

School-Based Health Center 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 Center. If a student is 18 or older, he/she may sign his or her own permission form. Demographic information is required by the State and will be used for statistical purposes only.

Student Name (First, Last, M.I.)	Birth Date (month/day/year)	☐ Male ☐ Female	Student's Cell Phone Number:
Address (Street, Town, State, ZIP code)		Home Number:	
Grade this year:	Please Check School ☐ Broadview Middle School ☐ Rogers Park Middle School ☐ Danbury High School ☐ ACE		

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

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

Emergency Contact Information		
Contact Name	Relationship to Student	
Home Phone Number	Work Phone Number	Cell Phone Number

Racial Background of the Student: (Please check one)
☐American Indian/Alaskan ☐Native Black/African American ☐White ☐Asian ☐Native Hawaiian/Other Pacific Islander

Is the Student Hispanic/Latino: (Please circle one) YES or NO In what country was the student born? _____

Is the student on the free or reduced lunch program? (Please circle one) YES or NO

Medical Care **Please provide a copy of the insurance card		**Dental Care** **Please provide a copy of the insurance card	
Does the student have **Medical Insurance:** YES or NO	Date of last physical exam:	Does the Student have **Dental Insurance**: YES or NO	Date of last dental exam:
Name of Doctor or Medical Clinic:		Name of Dentist:	
Address of Medical Provider **(Street, Town, State, ZIP)**		Address of Dentist **(Street, Town, State, ZIP)**	
Phone Number of Medical Provider		Phone Number of Dentist:	
Does the student have **MEDICAID Insurance:** YES or NO **Please provide a copy of the insurance card **If your child does not have health insurance** **Please call 1-877-CT-HUSKY** **Medicaid** #: _____ Insurance Company: _____ Child's name on Card: _____		Does the student have **Private/Commercial Insurance:** YES or NO **Please provide a copy of the insurance card Name of Insurance Company: _____ Policy Holders Name: _____ Policy Holders Date of Birth: _____ Policy Holders Address: _____ Policy Holders Employer: _____ Relationship to student: _____ Insurance Number for the student: _____ Group number:	

I have read the information regarding the 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 Danbury School Based Health Center and the Danbury 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 City of Danbury's School Based Health Center for services provided. My signature below also serves as acknowledgement that I have received a copy of the Danbury School Based Health Center's privacy policy as per federal law. **Unless I choose to withdraw my consent in writing, this authorization will continue for the entire period of time this student is enrolled in the Danbury school system.** Date: _____ Signature: _____Relationship to student: _____

Please turn this page over and complete the health information on the back of this form →

Student's Name: _____ Date of Birth: _____

Please list any medications that the student is currently taking: _____
_____
_____

Please check "**YES**" or "**NO**"
Please explain all "YES" answers in the space provided

Medical History	**NO**	**YES**	**(If YES, please explain)**
Allergies (i.e. food, medication, chemicals etc.)			
Problems with vision (contacts/glasses) and/or hearing			
Concussion (when?)			
Fainting or blacking out			
Heart Problems/Murmurs/Chest Pain			
High Blood Pressure/Cholesterol			
Problems Breathing/Coughing/Asthma			
Blood Disease/Disorders (i.e. Anemia, Sickle Cell, etc.)			
History of Seizures			
Diabetes/Thyroid/Endocrine			
Hospitalization or Emergency room visit			
Broken bones, dislocations, or other problems			
Muscle or joint injuries			
Neck or back injuries			
Running/exercise problems			
"Mono" (When?)			
TB or Positive skin test			
Dental Problems			
Females: Menstrual problems			
Weight or eating issues			
Has only one kidney or testicle or eye			
Other medical problems not addressed above:			

Mental Health History	**NO**	**YES**	**(If YES, please explain)**
Anxiety			
Mood disorder/depression			
Behavior problem			
Loss/divorce issues			
ADHD/ADD/Learning Disorder			
Autism/Aspergers			
Eating disorder/weight problem			
Cutting/self mutilation			
Smoking/Alcohol Use/Drugs			
Behavior/Mental Health Issues			
Other mental health problems not addressed above:			

Family History:	**NO**	**YES**	**(If YES, please explain)**
Any sudden unexplained death of a relative (who was less than 50 years old)			
Immediate family members with high cholesterol/diabetes			
Any other family medical problems not addressed above			
Any other family issues not addressed above			
Is the student under the care of any medical specialist (Explain)			

If you would like to speak with one of the School Based Health Center staff members regarding concerns you may have about your child, or for general SBHC questions, please call during school hours or as follows:

SBHC: Broadview Middle School	(203) 731-8274	Fax: (203) 731-8275
SBHC: Rogers Park Middle School	(203) 778-7479	Fax: (203) 778-7481
SBHC: Danbury High School	(203) 790-2886	Fax: (203) 797-4793