



School Name: _____

Grade: _____

Dear Parent or Guardian: Our School Based Health Center is pleased to provide medical and behavioral health services at your child's school during school hours. Please fill out this form and return it to the school with your child to enroll in the program.

Student Information	Last Name		First Name		MI	Date of Birth
	Street Address		City	State	Zip	Social Security Number
	<input type="checkbox"/> Public Housing <input type="checkbox"/> Homeless: If yes, please specify: <input type="checkbox"/> Shelter <input type="checkbox"/> Doubling up <input type="checkbox"/> Transitional <input type="checkbox"/> Other					
	Home Phone	Cell Phone	Work Phone	Email Address	Emergency Contact Person	Emergency Contact Number
	Sex	Language		Ethnicity	Race	
<input type="checkbox"/> M	<input type="checkbox"/> English	<input type="checkbox"/> French	<input type="checkbox"/> Hispanic/Latino	<input type="checkbox"/> Black	<input type="checkbox"/> White	<input type="checkbox"/> Asian
<input type="checkbox"/> F	<input type="checkbox"/> Spanish	<input type="checkbox"/> Indian	<input type="checkbox"/> Non-Hispanic/Latino	<input type="checkbox"/> American Indian/Alaskan Native		
	<input type="checkbox"/> Russian	<input type="checkbox"/> Other		<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Other Pacific Native	
				<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other	
				<input type="checkbox"/> Unreported or refuse to report		
Parent/Guardian Name _____			Parent/Guardian Date of Birth _____			
Insurance Information	Primary Medical Insurance		Insurance ID/Medicaid ID #		Group #	
	Policy Holder's Name		Policy Holder's Date of Birth		Policy Holder's Social Security #	
Income	My Annual Household Income is: _____ Total # of Dependents in Household (including patient): _____					

I give permission for my child to receive medical and behavioral health treatment/services by InterCommunity School Based Health Centers. I understand that this authorization is valid as long as my child is enrolled in the East Hartford School District or until I revoke this authorization with the Program Coordinator at InterCommunity School Based Health Centers.

I hereby authorize InterCommunity to use and disclose my child's protected health information (including both physical and mental health information) for treatment, payment and healthcare operation purposes, including the release of such information to process claims to my insurance company. I authorize direct payment from my insurance company to InterCommunity.

In the event that trained school personnel, such as school nurses or health aides, are not available to give prescribed medications taken routinely at school, I authorize InterCommunity staff to administer such medications to my child.

I consent to receiving phone calls regarding services my child receives or may be eligible to receive and agree to receive a copy of InterCommunity's Notice of Privacy Practices via email at the email address listed above. The Notice of Privacy Practices can also be accessed at www.intercommunityct.org/privacy-practices/.

By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I have read, understand, and agree with each of the above paragraphs and certify that all of the information provided is true and complete.

Signature _____ Date _____

I certify and attest that all of the above information is true and correct. I understand that InterCommunity may verify information on this form. I understand that the financial information will determine eligibility for the Center's sliding fee discount. I also understand that if I intentionally misrepresent my family's income, my child will not be eligible to receive services at a discounted rate. I understand that if my child is uninsured, my fee will be based on a sliding fee schedule. I also understand that I will be financially responsible for all charges incurred.

Signature _____ Date _____

Any protected health information released by InterCommunity that includes information that is protected by special state or federal laws, such as substance abuse treatment and HIV-related information, will be released in accordance with those laws. Please refer to InterCommunity's Notice of Privacy Practices, accessible at www.intercommunityct.org/privacy-practices/, for more information. InterCommunity's Notice of Privacy Practices also explains InterCommunity's ability to make your child's protected health information available to other providers through the Care Everywhere feature. Please contact InterCommunity's Privacy Officer at 860-569-5900 or compliance@intercommunityct.org to learn how to opt in to this convenient way to share your child's information with other providers.