CREC Schools of Excellence

School Based Health Centers

HEALTH HISTORY QUESTIONNAIRE

STUDENT NAME:	DATE OF BIRTH:

STUDENT HEALTH HISTORY

Medical Conditions	Medications/Supplements (name/dose/freq)	Allergies (allergen/reaction)
Disability (educational, medical, etc.)	Hospitalizations (reason/appx date)	Surgeries (type/appx date)

Smokers in the home? □Yes □No **If so, who?** □Student □Parent(s) □Sibling(s) □Other:
If so, where? □Indoors □Outside □In the car □Other:

STUDENT AND FAMILY HEALTH HISTORY

Please check below (YES OR NO) whether your child has had any of the following conditions. If BLOOD RELATIVES (i.e. parents, brothers/sisters, children, grandparents) have had any of the following illnesses note which relative had them:

STUDENT		FAMILY	CONDITION	STUDENT		FAMILY	CONDITION
Yes	No	List Relation		Yes	No	List Relation	
			Frequent Headaches				Muscle Pain/Swelling
			Seizures				Weakness
			Sleeping Problems				Eczema/Psoriasis
			Vision Problems/Wears Glasses				Hives
			Ear Pain/Frequent Infections				Hepatitis
			Trouble Hearing				Changes in Appetite
			Dental Problems				Weight Problems
			Dental Braces/Retainer				Diabetes
			Frequent Sore Throat				Thyroid Problems
			Seasonal Allergies				High Lead Levels
			Asthma				Violent/Aggressive Behavior
			Bronchitis/Pneumonia				Anxiety
			Difficulty Breathing/Wheezing				Depression
			Immune Deficiency				ADD/ADHD
			Cancer				Eating Disorder
			Blood Disorder				Moodiness
			Chest Pain				Running Away
			Heart Problems				Drug/Alcohol Use
			High Cholesterol				Trouble with the Law
			High Blood Pressure				Stealing
			Unexplained Death <50 Yrs Old				Bullying
			Problems with Digestion				HIV/AIDS
			Abdominal Pain				Other STD
			Vomiting				Chicken Pox
			Pregnancy				Measles
			Menstrual problems				Mumps
			Urinary Tract Infection				Rubella
			Hernia				Tuberculosis
			Broken Bone(s)				Meningitis
			Joint Pain/Swelling				Mononucleosis

Please explain any "yes" answers or indicate conditions not listed above: ____

____

____

This history is accurate to the best of my knowledge, and I will inform SBHC staff of any changes in my child's mental or physical health as soon as possible.

______________________________ ______________________________ ______________

Parent/Guardian Signature Parent/Guardian Printed Name Date

DEMOGRAPHIC, HIPAA AND INSURANCE INFORMATION FORM

Student Name:	**Date of Birth:**

DEMOGRAPHIC INFORMATION

Gender/Sex: □ M □ F	**Student's SS#:**	**Home Phone #:**

Student Address:	**City/State/Zip:**
School:	**Grade:**

OPTIONAL INFORMATION (For Tracking Purposes Only)

Race: (please check) □ Asian □ American Indian/Alaska Native □ Black/African American □ Native Hawaiian/Other Pacific Islander □ White □ Other:_________________________

Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Non-Latino

COMMUNICATION INFORMATION

Primary Language Spoken at Home:	**Other Languages Spoken at Home:**

Student Lives With: □Father □Mother □ Step-parent □Grandparent □Foster-parent □Other:

Primary Emergency Contact Name:	**Emergency Contact Phone #1**
Emergency Contact Phone #2	**Emergency Contact Phone #3**

Please list any other persons we may call with medical information or questions and their phone numbers:

HEALTH CARE PROVIDERS

Primary Care Provider & Town/Phone if Available:	**Dental Provider & Town/Phone if Available:**
Preferred Pharmacy & Town/Phone if Available	**Preferred Hospital:**

Student's Specialists or Other Health Care Providers (Specialty, Name &Town/Phone if Available):

INSURANCE INFORMATION AND PERMISSION

Please provide a copy of all insurance cards (front and back) if possible. Copies can be made at the school.

Is patient insured? □Yes □No **If so, please complete below**	**If not, would you like to speak with someone about obtaining insurance?** □Yes □No
Subscriber (Primary Insured) Is: □Student □Parent/Guardian □Other:	**Insurance Type:** □Private □HuskyA □HuskyB □Medicaid □Medicare □Other:

Insurance Carrier Name:	**Group Number#:**	**Student's Insurance ID #:**

Complete Below Only If The Student Is Not The Subscriber (Primary Insured)

Primary Insured's Name:	**Insured's DOB:**	**Insured's SS#:**

Insured's Address (if different from student address above):	**City/State/Zip:**

Insured's Home Phone:	**Insured's Work Phone:**	**Insured's Cell Phone:**

Relationship to Student (please check one): □Father □Mother □Other:

Insured's Employer:	**Employer Address, City, Zip:**	**Employer Phone:**

Additional information we should know:____

The information above is accurate to the best of my knowledge, and I will inform SBHC staff of any changes to the student's demographic information, allowed contacts, health care providers or insurance as soon as possible.

______________________________ ______________________________ ______________

Parent/Guardian Signature Parent/Guardian Printed Name Date

Student Name:	**Date of Birth:**

ENROLLMENT, AUTHORIZATION FOR TREATMENT AND EXCHANGE OF PROTECTED HEALTH INFORMATION, INSURANCE AUTHORIZATION AND HIPAA CONSENT AND ACKNOWLEDGEMENT

Please cross out any records you do not want shared, any persons with whom you do not want the records shared or any services to which you do not want your child to have access as allowed by law.

I understand that information regarding how Capitol Region Education Council (Practice) will use and disclose Protected Health Information (PHI) can be found in Practice's Notice of Privacy Practices which I have had the opportunity to review. I authorize the Practice to exchange, use or disclose, verbally, electronically or in writing all PHI maintained at any time as deemed necessary. Signing the authorization to exchange information is voluntary and Practice may not require me to sign this authorization before Practice provides me with treatment. Information exchanged may include:

- Medical Records: including history, examinations, intake/progress notes, prescription information, health summaries, diagnostic test results (laboratory or imaging), immunization records, treatment plans and appointments scheduled. This may include the electronic submission of prescriptions to a pharmacy through an electronic health record.
- Practice cannot use/disclose certain information unless you specifically authorize such use or disclosure. Please initial next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for: ____ HIV/AIDS ____ Drug and alcohol abuse ____ Mental or behavioral health/psychiatric disorders

This information may be shared with:

Any of the contacts or persons listed under "Communication Information" above
Any of the providers, hospitals or pharmacies listed above
The school nurse
The school guidance office
School administrators
Crisis or emergency services if needed
Laboratory and diagnostic services if needed
The following additional persons:____

Any information sharing under this release will be at the request of the individual requesting the information for the purposes of carrying out treatment, obtaining payment, conducting certain healthcare operations, coordinating and managing care and/or ensuring the safety of the patient or other students. Requests for other forms of information or information to be used for other purposes will require an additional release.

I have the right to revoke the authorization to exchange information at any time by providing a signed, written notice of such revocation to Practice. A description of my right to revoke my authorization is set forth in Practice's Notice of Privacy Practices. This consent is effective for as long as Practice maintains PHI for the patient listed above unless revoked by the student if over 18 years of age, otherwise by the student's parent or legal guardian at any time pursuant to the CT General Statute 19(a)-14c(b) and 17a-688(d) related to Adolescent Rights to Treatment and Confidentiality. I understand that the information released pursuant to this authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

By signing below, I understand and acknowledge that I have read and understand this Authorization and am authorizing Practice to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact: Timothy K. Carroll LCSW, Privacy Officer; tcarroll@crec.org, 860-289-8131, ext. 3408

I request that payment of authorized Insurance, Medicaid and Medicare benefits be made on my or my child's behalf to CREC for any services furnished by the CREC SBHC or Mental Health Clinic. I authorize any holder of medical information about me or my child to release to the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) and its agents or my insurance company any information needed to determine the benefits payable including HIV/AIDS, substance abuse, and/or mental health information for related services.

I give my child listed above permission to participate in the School-Based Health Center (SBHC) for medical (including laboratory and diagnostic services), dental and mental health services as needed and available. I understand that my child's Primary-Care Provider (PCP) continues to oversee his/her care and that I am responsible to ensure that the PCP receives copies of any records or treatment plans sent home. I have read the SBHC Introductory Letter and have had the opportunity to ask questions and have them answered to my satisfaction. I understand that I can contact the School Nurse or SBHC staff at any time with questions or concerns. I understand that the authorization for treatment will remain in effect as long as my student remains in a CREC school but may be rescinded in writing by the student if over 18 years of age, otherwise by the student's parent or legal guardian at any time pursuant to the CT General Statute 19(a)-14c(b) and 17a-688(d) related to Adolescent Rights to Treatment and Confidentiality. I attest that I have the legal right to sign this form for the listed student.

______________________________	______________________________	______________
Parent/Guardian Signature	Parent/Guardian Printed Name	Date

Authority of Personal Representative to Sign for Patient (check one): □ Self □ Parent □ Guardian □ Power of Attorney □ Other:____