The Eagle's Nest Enrollment Form

Parents-Please complete and sign BOTH SIDES of this enrollment form that allows your child to use the School-Based Health Center for the 2008-2009 school year.

Please note, this is an OPTIONAL SERVICE and DOES REQUIRE an enrollment fee, unless you have MaineCare. If interested, you need to re-enroll each year for this service.

If you are not interested you do not need to fill out or return this form to the school.

Date ________________________

Student Name________________________________ **Date of Birth**____________ **Social Security**____________
First MI Last

Race: White__ Black/African American__ Asian __ Am. Indian/Alaskan Native__ Native Hawaiian/Other Pacific Islander__ Two or More Races__ Other Race__

Ethnicity: Hispanic/Latino(a)__ Non-Hispanic__ **Gender:** Male____ Female____

Address ____**Zip code** ________**Home Phone** ________________

Grade________ **Parent/Guardian Name & relationship**____

Address of parent (if different):____

Home phone(s)__________________ **Work Phone(s)** ____

Cell Phone(s) ___________________________**Email**____

Doctor/PCP________________________________ **Phone #**_________________________________

Health Insurance Information

************Please send in a copy of insurance card if possible************

Consent to Release Information to My Insurance Carrier

I authorize release of medical and related information, reportable communicable disease, and mental health records obtained in the course of diagnosis and treatment to my health insurance company or other third party payer for the purpose of obtaining payment for service rendered. Authorization may be withdrawn at any time by written notification.

____________________________________ ____________________________
Signature of Parent/Guardian Date

Consent to use the School-Based Health Center

I give permission for my child,____, to use the School Based Health Center for the 2008-2009 school year.

* I understand that my signature indicates that I have received a copy of the **Notice of Privacy Practices**.
* I understand that my signature also gives permission for The Eagle's Nest staff to access my child's school health record, share health information with my child's doctor or dentist and share information with the school nurse or school social worker when it is deemed appropriate for treatment purposes.
* I give permission for the school nurse and clinic staff to administer as needed medications per the SBHC standing orders.

Parent/guardian signature____Date_____________
Student signature (if over 18)____Date______________________

********** Turn over-2 sided form, both sides MUST be filled out**********

Health Insurance Cont.

Students and their families will not be charged in addition to the annual enrollment fee for medical services provided by the MSAD No. 75 School-Based Health Center. MaineCare, Cigna, Aetna and Anthem-Blue Cross insurance carriers will be billed. No co-pays will be charged to you.

The student is covered by: (check all that apply)
No Insurance € Health Insurance € MaineCare €

MaineCare Recipient I.D. Number: ____

Insurance Company: ____
Insurance Co. Address: ____
Insurance Co. Phone #: ____
Policy #: ________________________________Group #: ________________________
Insurance Plan Type: HMO PPO POS Blue Choice Comp-Care Federal Other______________________________

Name of **policy holder**: ______________________________________Date of birth______________________________
Address of **policy holder**:____
Place of employment of **policy holder**:____
Relationship to student: ____

Student Health Information

Please list below any known medical issues or special health concerns that will help us manage your child's health needs.
Significant past illnesses, injury or hospitalizations:____
____
____
Current health problems:____
Current medications & dosages: medication_____________________________ dose___________
medication__________________________dose________ medication________________________ dose______________
Allergies____

Family Health History-Please circle where there is a family history of any of the following health conditions:
Heart attack Heart disease High blood pressure High cholesterol Allergies
Asthma Immune system disorder Diabetes Cancer Seizure disorder
Sickle cell disease Tuberculosis Alcohol or drug abuse Mental illness

Date of last Tetanus shot:________________________
Date of last complete physical exam:____
Date of last Dental appointment:____
Dentist:____________________________

There is a $20 enrollment fee.

If your insurance is billed, (CIGNA, ANTHEM, MAINECARE, and AETNA), this will help you meet your deductible and we charge NO co-pays.

Return this form to: MSAD # 75 School Based Health Center
73 Eagles Way
Topsham, Maine 04086

Or return to school with your child