SCHOOL-BASED HEALTH CENTER

☑ **REQUIRED FOR HEALTH CENTER REGISTRATION**
Please complete and return all required forms for Health Center Registration

REGISTRATION AND CONSENT FORM

Please fully complete and sign this form so we can provide high-quality healthcare services to you/your child. Students who are 18 or those seeking confidential mental health and/or reproductive health services that are at least 13 years old may complete for themselves. **This consent will remain active for the duration of the student's enrollment at the school served by the SBHC unless expressly revoked in writing.** To provide the best care possible, we also ask for demographics and family health history. You have the right to refuse to answer these questions. Your answers will not be shared or used for any purpose other than gathering general demographic information to best serve our patients and community.

What school does student attend?

1. STUDENT INFORMATION AND DEMOGRAPHICS

LAST NAME	FIRST NAME	MIDDLE NAME	PREVIOUS LAST	PREFERRED FIRST

STUDENT ID NUMBER	DATE OF BIRTH / / MONTH DATE YEAR	BIRTH SEX o Male o Female	LEGAL SEX o Male o Female o Nonbinary

MAILING ADDRESS	APT	SECONDARY ADDRESS (if different)	APT

CITY	STATE	ZIP	CITY	STATE	ZIP

STUDENT PHONE o Home o Mobile o Work ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___	STUDENT E-MAIL ADDRESS
	APPOINTMENT NOTIFICATION PREFERENCE (choose one) STUDENT o Text o Phone Call

GENDER IDENTITY	o Female o Male o Questioning	o Transgender Male to Female o Transgender Female to Male o Nonbinary/Gender Queer	o Other ___________________ o Choose not to disclose
SEXUAL ORIENTATION	o Straight o Lesbian o Bisexual o Gay o Queer o Pansexual		o Other:___________________________ o Choose not to disclose
PREFERRED PRONOUN	o She, Her, Hers o He, Him, His	o They, Them, Theirs o Other:	o Choose not to disclose
ARE YOU HISPANIC OR HISPANIC-LATINO?	o Yes, Hispanic or Latino	o Not Hispanic or Latino	o Choose not to disclose
WHAT IS YOUR RACE OR FAMILY BACKGROUND?	o American Indian/Alaska Native o Native Hawaiian o More than one race	o Asian o Other Pacific Islander o Declined to identify	o Black/African American o White

WHAT IS YOUR PREFERRED WRITTEN LANGUAGE?		DO YOU NEED AN INTERPRETER?	o Yes o No

2. PARENT/GUARDIAN (IF PATIENT IS UNDER 18)

PARENT/GUARDIAN'S LAST NAME	PARENT/GUARDIAN'S FIRST NAME	DATE OF BIRTH / /	SEX o Male o Female

MAILING ADDRESS	APT	RELATIONSHIP TO PATIENT o Parent o Guardian o Other

CITY	STATE	ZIP	PHONE o Home o Mobile o Work ___ ___ ___ – ___ ___ ___ – ___ ___ ___ ___

PARENT E-MAIL ADDRESS	APPOINTMENT NOTIFICATION PREFERENCE (choose one) PARENT o Text o Phone Call

The SBHC program is provided at no cost to you, but we will bill your insurance if you have any to support the cost of program operations. If your insurance does not cover the entire cost, you will not be billed.

3. INSURANCE		
DO YOU HAVE INSURANCE?	o Yes o No	
PLEASE LIST INSURANCE COVERAGE INFORMATION	NAME OF INSURANCE	EFFECTIVE DATE
	GROUP PLAN NUMBER	MEMBER ID #
	SUBSCRIBER/POLICY HOLDER NAME	SUBSCRIBER DATE OF BIRTH
PLEASE LIST ADDITIONAL INSURANCE COVERAGE INFORMATION IF APPLICABLE *Examples: dental insurance, secondary coverage, etc.*	NAME OF INSURANCE	EFFECTIVE DATE
	GROUP PLAN NUMBER	MEMBER ID #
	SUBSCRIBER/POLICY HOLDER NAME	SUBSCRIBER DATE OF BIRTH
If you don't have insurance, would you like a CHC staff member to contact you to see if your family qualifies?		o Yes o No

4. ADDITIONAL QUESTIONS (Answer for patient or, if patient is a minor, please answer for legal guardian.)				
YEARLY OR MONTHLY INCOME	What is your household's annual (yearly) gross income?	$	If easier to calculate, what is your household's monthly income?	$
TOTAL NUMBER IN HOUSEHOLD				
HOUSING STATUS	o Rent/Own o Public Housing o Doubling Up o Shelter o Other o Street o Permanent Supportive Housing o Transitional			
MIGRANT/SEASONAL WORK STATUS	At any point in the past two years, has seasonal or migrant farm work been your or you family's main source of income?		o No o Yes, Migrant Farm Work o Yes, Seasonal Farm Work	

5. STUDENT HEALTH HISTORY

❑ Yes	❑ No	Does your child have a primary care doctor or clinic? Provider Name: Clinic: Phone:
❑ Yes	❑ No	Has your child had a well child checkup or full physical in the past year?
❑ Yes	❑ No	Has your child seen a dentist in the past year?
❑ Yes	❑ No	Does your child have any medication or other allergies? (Describe):
❑ Yes	❑ No	Does your child take any medications? (List any medications and reason)
❑ Yes	❑ No	Does your child have any ongoing health problems or current health concerns? (Describe):

Family Health History (Check all that apply)

☐ Alcohol/Drug Use	☐ Arthritis
☐ Asthma	☐ Cancer
☐ Depression	☐ Diabetes
☐ Hypertension	☐ Heart Problems
☐ High Cholesterol	☐ Kidney Disease
☐ Mental Illness	☐ Stroke
☐ Vision problems	☐ Other:___________________

6. PRIVACY NOTICE

I hereby acknowledge under the Health Insurance Portability and Accountability Act (HIPAA), I have rights to privacy regarding my protected health information. I understand CHC of Snohomish County may contact me about appointment reminders, treatment options, test results or other health related benefits and services via phone call, text message, email, or voicemail. I hereby acknowledge I have access to CHC's Notice of Privacy Practices on the CHC website and can request the practices in another format at any time by contacting: Community Health Center of Snohomish County, 8609 Evergreen Way Everett, WA 98208, (425)789-3700, www.chcsno.org.	Initials

7. RELEASE AND CONSENT SIGNATURE

CERTIFICATION OF INFORMATION AND CONSENT FOR CARE: I certify that the registration information that I have reported to Community Health Center of Snohomish County (CHC) is currently correct. I grant permission to CHC staff to employ such established treatments and therapies deemed professionally and medically necessary or advisable in the diagnosis and treatment of health problem(s). I understand that the medical care may be given by a Physician, Nurse Practitioner, Physician Assistant, or other licensed staff. I understand that the mental health care may be given by a Licensed Social Worker, Licensed Mental Health Counselor, or other licensed staff. I understand that dental care may be given by a licensed Dentist, Dental Hygienists, or other Dental provider in accordance with the Washington State Dental Practice Act. This release authorizes CHC to release to my insurance company, CMS or DSHS any information needed to determine the benefits payable for related services. I hereby authorize any insurance carrier with whom I have a policy to pay directly any benefits of any policies of insurance to those health care providers who have rendered services to me.

SIGNATURE	RELATIONSHIP TO PATIENT	DATE / /

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CONSENT FOR HEALTH SERVICES

CHC must have signed consent from a parent or legal guardian before providing services, except in situations where federal or state laws allow the student to access treatment without parent/guardian consent. Students do not need to be registered at the health center to receive services from the school nurse.

I hereby request and authorize that: (Print student's name below.)

First Name	Middle Initial	Last Name	Date of Birth
			/ /

May receive health care services available from and deemed necessary by the Community Health Center of Snohomish County (CHC) School-based Health Center (SBHC) staff. These services may include but are not limited to: Routine medical and dental exams, sports physicals, well-child or teen care, evaluation and treatment of acute illness or injury, laboratory testing, dental x-rays, fluoride treatment, sealant, and limited dental treatment including fillings and simple extractions, and mental health therapy. This care may occur both in-person or remotely via phone or virtual telehealth visit. Consent is also given for referral of care and, if needed, emergency transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies as deemed necessary by the CHC SBHC staff. This authorization does not allow services to be rendered without the student's consent unless the student is unable to consent. Additional consent is required for vaccinations.

In accordance with state and/or federal law, when consent is provided for care, health care information is kept confidential. A few exceptions exist; for example:

- Permission is given by the patient or parent/guardian through a signed release of information form
- The patient indicates risk of imminent harm to self or others
- The patient has a life-threatening health problem and is under the age of 18
- There is reason to suspect abuse or neglect
- Certain communicable diseases must be reported to public health authorities.

Consent is given to share necessary information between the health care providers at the SBHC, including exchange of information with the school nurse and other co-located medical professionals for the purpose of providing the best care for the above-named student. Students may also receive health services independently at any of CHC's medical or dental clinics. With this consent, services can be received at any CHC of Snohomish County medical and dental clinic. To see a list of clinic locations, please visit our website at chcsno.org. To schedule an appointment, call CHC at 425-789-3789

Student Signature: *(Required for 13 and older)*	Date: / /
Parent/Guardian Signature:	Date: / /
Name of Legally Responsible Guardian (Print):	Relationship:

IMPORTANT ADDITIONAL INFORMATION ON MINOR CONSENT

The SBHC encourages students to involve their parents or guardians in health care decisions whenever possible and when applicable, the SBHC will assist the student in discussions with parents/guardians. Under Washington State law, youth may independently access reproductive health care at any age without parental/guardian consent. Youth (age 13 and older) may independently receive drug and alcohol services and mental health treatment without parental consent. Consent from the student is required to release information regarding their reproductive/sexual health, mental health (13 and older), and/or substance use (13 and older). For more information on minor consent visit: www.washingtonlawhelp.org and search "Minor Consent."