Do you need an interpreter? No___ Yes___ If Yes, what language? _____ Today's Date: _____

CLIENT DEMOGRAPHICS

Preferred Name: _____ Birth Date: _____

Legal Name Last: _____ First: _____ Middle: _____

Gender: Male Female Other _____ **Ethnicity:** Hispanic___ Non-Hispanic___ SSN: _____-___-_____

Race: Alaskan Native___ American Indian___ Asian___ Black___ Native Hawaiian___ Pacific Islander___ White___ Other_____

Address: _____ Apt#_____ City/State_____ Zip:_____

Client Cell Phone: _____ Voicemail OK? Yes___ No___ OK to text? Yes___ No___

Client Home Phone: _____ Voicemail OK? Yes___ No___ OK to text? Yes___ No___

Primary Care Physician: _____ Preferred Pharmacy: _____

Parent/Guardian:_____ Relationship:_____ Work #_____ Cell#_____

Parent/Guardian:_____ Relationship:_____ Work #_____ Cell#_____

Emergency Contact (if above unavailable) _____ Relationship:_____ Phn# _____

School age youth in Union County are eligible for care at a CHD SBHC regardless of insurance status.

Do you have insurance coverage? Yes___ No___ Copy of Insurance Card? Yes___ No___

INSURANCE INFORMATION

Students are NOT responsible for any out of pocket cost for SBHC visits, except for sports physicals and some immunizations. Other fees not covered by insurance or incurred by uninsured students are covered by the SBHC program funds. Providing us with your insurance information allows us to collect on any covered services and put that money back into the SBHC program. You may receive an EOB (explanation of benefits) from your insurance company, but this is **NOT A BILL** from CHD or the SBHC.

Insurance Company:_____ Policy/ID#_____ Group#_____

CONSENT TO RELEASE INFORMATION TO MY INSURANCE CARRIER:

I authorize the release of any medical information necessary to process claims to my insurance carrier. I authorize payment of medical benefits for services received at the CHD SBHC to the Center for Human Development, Inc. I understand that there will be no out of pocket expenses for these services, with the exception of sports physicals and immunizations. Other costs not covered by insurance will be covered by the CHD SBHC program.

Signature of Parent/Guardian/Client_____Today's Date_____

OVER ⇨

TREATMENT CONSENT (K-12)

Client Name: _____ Birth Date: _____

Client Legal Name (if different): _____Today's Date:_____

I give my permission for the CHD School Based Health Centers (SBHC), operated by the Center for Human Development, Inc. to provide care to the person named above.

I understand that the following types of services are offered through the SBHC:

- Wellness exams, including sports physicals
- Diagnosis and treatment of illness and injuries
- Vision screenings
- Nutrition education and weight management
- Classroom presentations
- Referral for services not provided at the SBHC
- Mental Health Counseling, Individual, Family and A&D
- Age appropriate reproductive health & education
- Immunizations
- Medication prescriptions
- Over the counter medications
- Routine lab tests

MEDICATION CONSENT

I give my permission for the SBHC to administer over-the-counter medications when deemed necessary by clinic staff.

ALLERGY ALERT: Does the client have any allergies? Yes No

List ALL allergies; including medication, foods, latex, insect stings/bites or others: _____

_____

_____

I have read the above information and have had the opportunity to have any questions answered.

I give my permission for SBHC staff to access school district registration information about the above client including class schedules, emergency contacts, allergies, immunization records, medications and demographics as necessary for treatment.

I understand that I may revoke my consent at any time by submitting a written notice to the SBHC.*

Signature Parent/Guardian /Client_____ Today's Date_____

*Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age except for family planning, sexually transmitted disease services and certain mental health services, ORS 109.640, ORS 109.675; for mental health services, a parent/guardian signature is required for clients under 14 years of age ORS 109.675.

OVER ⇨