Health Partnership CLINIC

School-Based Portable Care

Your child's school has been selected to participate in the School Health Care Program, administered by the local non-profit Health Partnership Clinic (HPC). HPC providers will be offering medical, behavioral health and/or dental services in your child's school. Upon request, the HPC provider will provide you with a report card of the treatment completed and/or treatment remaining.

SCHOOL LOCATION: _____

Child's Last Name:	Child's First Name:	DOB:	Gender:	Race:	Language:
Street Address:	City/Zip:	Phone:	SSN:		
Insurance Name & Member ID #:					

Guardian's Name:	Relationship with Patient:	DOB:	Gender:
Street Address:	City:	Zip:	Phone:
Insurance Name & Member ID #:		Email Address:	

EMERGENCY CONTACT

NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____ CITY: _____ ZIP: _____

TELEPHONE NUMBER: _____ RELATIONSHIP: _____

AUTHORIZATION FOR DISCLOSURE: I give express permission to discuss my child's health and financial information with the following individual(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

CONSENT: *I give Health Partnership Clinic (HPC) permission to provide medical, behavioral health, and/or dental services to my child. Dental care services include: comprehensive dental exam & x-rays, sealants, removal of baby teeth, cleaning, filling cavities, fluoride (up to 3 per year), baby tooth root canals, and oral health education. Dental video conferencing technology could be used to affect a consultation. This will not be the same as a direct patient/health care provider visit due to the fact that the dentist will not be in the same room as the health care provider. Consent is valid for one year from the date of my signature unless otherwise noted by me.*

Parent/Guardian Print Name: _____

Parent/Guardian Signature: _____ **Date:** _____

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Please note, the federal government requires us to ask you for this information, and it will be used for government reporting purposes only. Neither your name nor any other identifying information will ever be disclosed, and we will not use this information for any other purpose.

Please circle your family size and the range of your annual income.

Family Size	A	B	C	D	E
1	$0 - $12,880	$12,881 - $17,130	$17,131 - $21,381	$21,382 - $25,520	$25,760 or greater
2	$0 - $17,420	$17,421 - $23,169	$23,170 - $28,917	$28,918 - $34,480	$34,840 or greater
3	$0 - $21,960	$21,961 - $29,207	$29,208 - $36,454	$36,455 - $43,440	$43,920 or greater
4	$0 - $26,500	$26,501 - $35,245	$35,246 - $43,990	$43,991 - $52,400	$53,000 or greater
5	$0 - $31,040	$31,041 - $41,283	$41,284 - $51,526	$51,527 - $61,360	$62,080 or greater
6	$0 - $35,580	$35,581 - $47,321	$47,322 - $59,063	$59,064 - $70,320	$71,160 or greater
7	$0 - $40,120	$40,121 - $53,360	$53,361 - $66,599	$66,600 - $79,280	$80,240 or greater
8	$0 - $44,660	$44,661 - $59,398	$59,399 - $74,136	$74,137 - $88,240	$89,320 or greater

Outreach Health Care Program HEALTH HISTORY

HPC will treat all patient information as protected health information (PHI) under HIPPA regulations, exchanging the PHI only with personnel employed by HPC and the facility/school who are responsible for medical treatment and/or record review.

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MEDICAL HISTORY

History (check all that apply):

Diabetes_____Asthma_____Autism_____Seizure Disorder_____Hepatitis_____Artificial Joints/Pins/Screws_____
Heart Disease_Heart Murmur_____Artificial Heart Valve__Congenital Heart Disorder_____
Other_____

Allergies (check all that apply)

Latex_____Amoxicillin/Penicillin_____Other_____

List all medications your child is taking: _____

List any surgeries, hospitalizations, or other medical conditions: _____

List special healthcare needs or any additional information you think might help HPC providers meet your child's needs:

_____

When did your child last see a medical provider?

In the past year_____More than one year ago_____Never_____
Other (please explain): _____

BEHAVIORAL HEALTH HISTORY

Previous/Current Inpatient or Outpatient Mental Health Services (please list name of Hospital, Organization and/or Counselor)

_____

Medication your child is currently taking for mental health purposes: _____

DENTAL HISTORY

When did your child last see a dentist?

In the last year _____ More than one year ago_____ Never _____
Other (please explain):_____

Is your child required to take pre-medication (antibiotics) prior to dental treatment? Yes _____ No _____

If yes, for what condition? _____