



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:** _____

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 - \$13,590	\$13,591 - \$18,075	\$18,076 - \$22,559	\$22,560 - \$27,180	\$27,181 or greater
2	\$0 - \$18,310	\$18,311 - \$24,352	\$24,353 - \$30,395	\$30,396 - \$36,620	\$36,621 or greater
3	\$0 - \$23,030	\$23,031 - \$30,630	\$30,631 - \$38,230	\$38,231 - \$46,060	\$46,061 or greater
4	\$0 - \$27,750	\$27,751 - \$36,908	\$36,909 - \$46,065	\$46,066 - \$55,500	\$55,501 or greater
5	\$0 - \$32,470	\$32,471 - \$43,185	\$43,186 - \$53,900	\$53,901 - \$64,940	\$64,941 or greater
6	\$0 - \$37,190	\$37,191 - \$49,463	\$49,464 - \$61,735	\$61,736 - \$74,380	\$74,381 or greater
7	\$0 - \$41,910	\$41,911 - \$55,740	\$55,741 - \$69,571	\$69,572 - \$83,820	\$83,821 or greater
8	\$0 - \$46,630	\$46,631 - \$62,018	\$62,019 - \$77,406	\$77,407 - \$93,260	\$93,261 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? _____