2022-2023
Summit School Based Health Center Enrollment Form

Healthy Kids Learn Better

School Based Health Center provides in school access to medical, behavioral, and dental care. Studies show students who use School Based Health Centers miss less school. We collaborate with the school nurse and counselors to provide quality care. A parent or guardian must sign up their student for SBHC services. Written notice can stop access at any time.

Students in PreK - 5th grade must have a parent or guardian present for medical care. Students in 6-12th grade can attend an appointment by themselves. We encourage students to have their family involved in their care.

Students, family, and staff may access services at the below locations:

Dillon Valley Elementary	Summit Middle School
Silverthorne Elementary	Summit High School

Enrollment in SBHC allows your student the following services:

Yearly Medical Check-Up (Well Child Check)	Refer you to other healthcare specialists
Sports Physicals	Substance-Abuse prevention, education, and counseling
Care for common cold, infections, injuries, & other acute illnesses (may include strep testing)	Behavioral health services which may include individual, family, and group visits
Prescriptions for illnesses and other medications	Health Education
Assistance in the care of chronic conditions	Dental cleanings and x-rays
Risk assessments including depression & anxiety	Family planning education and counseling

Telehealth

Are you interested in receiving care through a video call (Telehealth) _____ Yes _____ No

Vaccine Consent

We offer vaccines for students, staff, and families. At each visit, we require a parent or guardian's consent for vaccines. I consent for my student to receive vaccines at the School Based Health Center.

Signature Required _____ Date_____

Healthy Smiles Program

School Based Health Center provides dental care. There will be no charge for the services listed below. Please mark yes or no for the below services.

- I give consent for my child to receive an oral health screening. ____Yes ____No
- I give consent for my child to receive fluoride varnish application. ____Yes ____No
- I give consent for my child to received dental sealants. ____Yes ____No

Dental insurance covers the below services. If you do not have dental insurance, these services will only be **$25.** Please mark yes or no for the below services.

- I give consent for my child to receive dental cleaning. ____Yes ____No
- I give consent for my child to receive dental x-rays. ____Yes ____No

When was your child's last visit to a dentist?

____0-6 months ago ____6-12 months ago ____More than a year ago ____Never

PLEASE COMPLETE BOTH SIDES

Enrollment Information

Student First Name _____ Last Name _____ Date of Birth _____

Current Grade_____ Student Social Security Number _____ Student Phone Number_____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Physical Address _____ City _____ State _____ Zip Code _____

*Below please put the address you receive mail at. If you do not have a mailing address, please check this box: ☐

Mailing Address _____ City _____ State _____ Zip Code _____

Email Address _____ Student Email Address_____

Does your student have a Primary Care Provider (Please Circle): **YES** **NO** If yes, who? _____

***** Please complete the below section. This demographic data is used to secure grant funding to keep our services affordable.**

RACE *(CIRCLE AT LEAST ONE)*		**PRIMARY LANGUAGE** *(CIRCLE AT LEAST ONE)*	**SEXUAL ORIENTATION** *(CIRCLE ONE)*	**ETHNICITY** *(CIRCLE ONE)*	**GENDER IDENTITY** *(CIRCLE ONE)*
BLACK OR AFRICAN AMERICAN		AMERICAN SIGN LANGUAGE	STRAIGHT	HISPANIC/LATINO ORIGIN	MALE
AMERICAN INDIAN OR ALASKA NATIVE		ENGLISH	BISEXUAL	NOT HISPANIC/LATINO ORIGIN	FEMALE
ASIAN		FRENCH	LESBIAN	NOT PROVIDED	GENDERQUEER/NONBINARY
WHITE		POLISH	GAY		TRANSGENDER WOMAN/ TRANSGENDER FEMALE
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	SOMETHING ELSE		TRANSGENDER MAN/ TRANSGENDER MALE
NOT PROVIDED		SPANISH	DO NOT KNOW		OTHER
		OTHER	CHOOSE NOT TO DISCLOSE		CHOOSE NOT TO DISCLOSE

Financial Arrangements

We will bill your insurance. The maximum out-of-pocket cost you will pay for services is:

- Yearly Medical Exam (Well Child Check): $25
- Sports Physical: $30
- Vaccine Visits: $45
- All other Medical Visits: $45
- Dental Visits: $25
- Behavioral Health Visits: $15

Please mark your student's **medical** insurance type:

___ Medicaid Member ID # _____

___ CHP+ Member ID #_____

___ Summit Community Care Card (sliding fee) – If you are interested in learning about this, please check this box: ☐

___ Uninsured (do not have health insurance)

___ Unknown

___ Private Insurance Name_____ Member ID # _____

Group Number_____ Insured Subscriber _____

Date of Birth of Subscriber _____ Relationship to Subscriber_____

I have read, understand, and consent to the services offered by the School Based Health Centers (SBHC). I understand that my child's attendance, vaccine records, basic information and school schedule may be shared between school and SBHC staff to provide quality care for my child. I have been offered a copy of the SBHC's Notice of Privacy Practices. A copy of this notice is available on the Summit Community Care Clinic web site**:** https://www.summitclinic.org/index.php/patient-info

I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services I receive at the School Based Health Center. CDPHE is legally able to receive data regarding services provided to patients. **This data does not identify any individual patient.**

I authorize the School Based Health Centers to bill and receive payment from any third party payors and to provide any portion of my child's medical record as needed to bill and receive payment for services.

I/We agree to the SBHC enrollment requirements (please mark) _____ YES & _____ Initial

Signature: _____ Date: _____