InterCommunity, Inc. School Based Health Center
ENROLLMENT FORM

Student Name: _____ **(please print)** **Today's Date:** _____

School: _____ **Grade:** _____

Student Information

Name and Demographics	**First**	**Last**	**What name would you like to be called?**	
	Date of Birth	**Age**	**Sex ( ) Male ( ) Female**	**Social Security #**
	Student's School		**Grade**	
Address	**Street**			
	City		**State**	**Zip Code**
Parent/ Legal Guardian Information	**Name**		**( ) Parent ( ) Legal Guardian**	
	Street (if different from patient's)			
	City		**State**	**Zip Code**
Phone Number	**Home**	**Cell**	**Work**	
Email Address		**Preferred Method of Contact**		
Emergency Contact	**Name**	**Relationship**	**Phone #**	
Race/ Ethnicity	☐ **African/African American** ☐ **Asian/Asian American** ☐ **White/Caucasian** ☐ **Native American or Native Alaska** ☐ **Native Hawaiian/Other Pacific Islander** ☐ **Other_____** ☐ **Hispanic/Latino** ☐ **Non-Hispanic/Latino**			
Primary Language				
Living Status	**Who lives with you in your home(s)?**			

Other Medical Provider Information

List Medical Providers (doctors, APRNs) seen on a regular basis, please include hospital/clinic/urgent care

Name/Location	**Phone**	**( ) Primary Care Provider**
Name/Location	**Phone**	**( ) Dentist _____**
Name/Location	**Phone**	**( ) Specialty _____**
Name/Location	**Phone**	**( ) Specialty _____**
Pharmacy Name/ Location		**Phone**
Please list any Hospitalizations/ Surgeries with approximate dates		

Insurance Information

1. **Medicaid/Husky: Student's Medicaid # _____**

2. **Private Insurance Company Name _____ Policy #_____ Group #_____**

Policyholder's Name _____ Relationship to Student _____

Policyholder's Employer _____ Employer's Address _____

Do you have Secondary Insurance? ☐ Yes ☐ No

3. ☐ **The student does not currently have insurance and would like help applying for insurance for the student**

4. **Combined yearly household income: $_____ Total Number of Dependents in household (including patient): _____**

Student Medical History

Please indicate if your child has problems in any of these areas:

General	☐ Anemia/Blood disease ☐ Energy level ☐ Joint/ muscle pain ☐ STDs	☐ Chicken Pox ☐ Feeling hot/cold all the time ☐ Sleeping at night ☐ Irregular menstrual periods (girls)	☐ Diabetes ☐ Frequent headaches ☐ Weight
Respiratory	☐ Asthma	☐ Chronic cough	☐ Shortness of breath
Eyes/ENT	☐ Difficulty seeing ☐ Wear glasses/contacts	☐ Difficulty hearing ☐ Wear hearing aids	☐ Frequent ear/sinus infections ☐ Frequent sore throats
Skin	☐ Significant Acne	☐ Dry Skin	☐ Rashes
Gastrointestinal	☐ Abdominal pain ☐ Diarrhea	☐ Appetite ☐ Frequent Stomach Aches	☐ Constipation
Urinary	☐ Excessive thirst ☐ Accidents	☐ Frequent Urination ☐ Urinary Tract Infections	☐Awakening at night to urinate
CNS	☐ Headaches	☐ Seizures	☐ Poor coordination
Behavioral	☐ Anxiety ☐ Drug/ Alcohol Use ☐ Other:	☐ Attention difficulties ☐ Conduct (sustentions, etc.)	☐ Depression ☐ Social Issues/ Isolation
Immune	☐ Allergy to medications	☐ Environmental allergies	**Please list any Allergies & Reactions**

Current Medications (please include over the counter medications and food supplements)	**Drug Name**	**Dose**	**How Often?**	**Drug Name**	**Dose**	**How Often?**

Last Physical Examination	**When was the date of your last physical examination? _____** **Where? _____**
Other Important Medical Information	**Please let us know of any other important medical information about the student or their family**