CAMARENA HEALTH

We are community. We are family. We are health.

School Based Health Center

Student Information

Parent/Legal Guardian (First & Last Name) **1.**	**Relationship:**		**Date of Birth:**
Parent/Legal Guardian (First & Last Name) **2.**	**Relationship:**		**Date of Birth:**
Student (First & Last Name) **3.**	**Gender: M / F** **Grade:**	**Student ID#**	**Date of Birth:**

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number_____ Alternate Number_____ Alternate Contact Name _____

Student Insurance Information: ***Check all that apply***

☐ Private Medical Insurance ☐ Dental Insurance ☐ Medi-Cal ☐ No Coverage ☐ Other

Insurance Name: _____ ID/Policy#_____ Insured Name: _____

Insurance Name: _____ ID/Policy#_____ Insured Name: _____

Ethnicity: ☐ Caucasian ☐ Hispanic/Latino ☐ African-American ☐ Native American ☐ Asian ☐ Pacific Islander ☐ Multi-Racial ☐ Other: _____ ☐ Decline to State

1. **Are you or have you ever been a Camarena Health patient? ☐ Yes ☐ No**
2. **Is Camarena Health your students' Primary Care Provider (PCP)? ☐ Yes ☐ No**
3. **Would you like to apply for our Sliding Fee Program? ☐ Yes ☐ No**
4. In the past 2 years, have you or anyone in your family, worked in any type of agriculture(farm work) like: ☐ Yes ☐ No

   Planting, picking, preparing the soil, packing house, driving a truck for any type of farm work, worked with live stock, etc.?
5. In the past 2 years, have you or a member of your family lived away from home in order to work in agriculture? ☐ Yes ☐ No
6. Have you or a member of your family stopped migrating to work in agriculture because of a disability or age? ☐ Yes ☐ No

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Medical Questions Regarding Student:

1. Is the Student currently taking any type of medications? (This includes over the counter medications) □ Yes □ No

   If yes, list all medications:

   _____
2. Does the Student have any Allergies? □ Yes □ No

   If yes, list all allergies:

   _____
3. What is your preferred Pharmacy? Name:_____Location:_____

I certify that the above information is true and accurate to the best of my knowledge.

Signature: _____ Date: _____

(Parent or Legal Guardian)

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Parental Consent Form

Student Name: _____ Date of Birth: _____ Grade: _____ Student ID#_____

I authorize a physician or other designated health center staff to provide the following services In accordance with all federal and state laws:

□ Yes □ No **Medical Services:** comprehensive physical exams, management of acute and chronic illness, sport, college, and employment physicals, immunizations, first aid, vision and hearing screening, lab tests (anemia, urine), and referrals to higher level care as appropriate

□ Yes □ No **Dental Services:** dental exams, x-rays, cleaning, sealants, fluoride treatment, fillings, extractions, root canals, and crowns

□ Yes □ No **Counseling/Therapy Services:** crisis management, depression, anxiety, behavioral modifications, solution focus therapy, relationship and family issues, stress, low self-esteem, body image issues, eating disorders, and other behavioral health issues

I consent to the exchange of my child's medical information between Madera Unified School District (MUSD) and Camarena Health School Based Health Center for the purposes of delivering the above authorized services. This exchange of medical information shall be bi-directional between MUSD and Camarena Health. I understand the Camarena Health student medical records will be maintained as confidential medical records separate from school records, but may be shared with other health care providers for the purposes of my child's care and treatment.

I understand that my son/daughter will not receive services in the Camarena Health School Based Health Center unless a consent form is on file. I understand that I may at any time during my child's enrollment withdraw this consent through a written notice. Otherwise, it will apply for the duration of my child's enrollment in school.

I authorize Camarena Health School Based Health Center to release information regarding treatment to third party payers or others for the purpose of billing or for any reason that may be required to comply with the statutes or regulation in accordance with accepted medical practice. I understand that I am responsible for any charges/fees not covered by my insurance carrier.

Print Name of Parent/Legal Guardian: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Student Signature: _____ Date: _____