

Dear Norwalk High School Parents & Guardians:

As you may or may not be aware, Norwalk Public Schools will not be vaccinating students against the H1N1 virus. The School Based Health Center has begun to vaccinate students as of Friday, November 6th. While hundreds of vaccines have been ordered, **very limited numbers have been received.**

In order for your child to be vaccinated by the School Based Health Center two different forms must be received: the standard SBHC permission form as well as the H1N1 Vaccine Administration Record. We are in the process of making both forms available for download on the NHS website. You may also call the SBHC to find out where you can pick one up.

During the heightened period when only **limited quantities have been received**, we will vaccinate students according to State of CT DPH **priority guidelines:**

Students with chronic illnesses or underlying medical conditions such as asthma or diabetes.

Pregnant students or teen parents of infants less than six months of age.

As the vaccine becomes more widely available we will expand to healthy children aged 2 to 18 years old. Unfortunately we will not be able to accommodate siblings at other NPS schools or parents of NHS students. You should make every attempt to contact your private doctor, the Norwalk Health Department or the Norwalk Community Health Center.

If you have any questions please contact the SBHC at 838-4481 x 13340.

Dr. Robert Appleby School Based Health Center

NAME _____ DOB _____
AGE _____

Are you now pregnant? Y ____ N ____

Have you had a recent seasonal influenza immunization? Y ____ N ____

If yes, when/where? _____

Do you have any illness now? Y ____ N ____ Describe _____

Any chronic illnesses? Y ____ N ____ Describe _____

Do you have any allergies? Y ____ N ____ If yes, what? _____

Eggs, Y ____ N ____

Sulfites, Y ____ N ____ , Thimerisol (in contact lens solution) Y ____ N ____

I have read the fact sheet on the _____) vaccine. I have had a chance to ask questions which were answered to my satisfaction. To the best of my knowledge, I am not allergic to eggs and I do not have a fever at this time.

I understand the benefits and risks of the flu vaccine and request that this vaccine be given to me.

Signature of person to receive vaccine

Date

TO BE COMPLETED BY HEALTH CARE PROVIDER:

Date vaccine administered _____

Vaccine manufacturer _____ Lot number _____

Exp. Date _____ Site of injection _____

Sarah Siegel, M.D.

Mary Beth Fessler, A.P.R.N.

Julia Sparkman, A.P.R.N.

Rose Sferlazza, P.A.-C

Nelly Rabinowitz, P.A.-C

**DR. ROBERT E. APPLEBY SCHOOL BASED HEALTH CENTERS
PERMISSION FORM**

I give permission for the student identified in this application to obtain services at the Dr. Robert E. Appleby School Based Health Centers, (REASBHC) while he/she is in school. The permission will remain in effect unless I withdraw it or if my child/guard is no longer attending Norwalk Public Schools.

I understand that all services provided to the student and records of such are **CONFIDENTIAL** to the student, and will not be released or discussed without written or verbal permission from the student, except in **LIFE THREATENING OR EMERGENCY SITUATIONS**, and in accordance with Connecticut State and Federal laws. In the event the student is referred to Norwalk Hospital, or any other hospital or treatment facility for evaluation and/or treatment, I give permission to the respective hospital/facility staff to release related treatment information to The Dr. Robert E. Appleby School Based Health Centers. A copy of the treatment plan should be sent with the student or faxed to the respective School Based Health Center as soon as possible. For services **not** provided by the (REASBHC), I further understand that the above named student may be referred to community agencies and specialists. Services such as those may not be free and therefore, the parent must negotiate fees in advance if these services are recommended and/or needed. Please inform us of any changes such as insurance status, employment, phone numbers, and include a copy of your current insurance card with this form. Please provide us with a copy of your insurance card **every** time you change carriers.

In signing this permission form, I acknowledge that I understand the services the (REASBHC) provides. I have been given the opportunity to ask questions before enrolling my child/guard.

I understand and acknowledge that the Norwalk Board of Education ("The Board") has no responsibility or liability for the services rendered by the (REASBHC) and that the (REASBHC) is independently operated through the Human Services Council. "The Board" is kindly providing space for (REASBHC) and has no legal relationship with them. We hereby release "The Board," and waive any and all claims, which we may have or make against "The Board" in any way related to or arising out of the REASBHC or any services rendered by them.

Student Name

Parent/Guardian/Other Signature

Date

School Based Health Center Services include:

- Health screenings and health education programs
- Treatment of minor illnesses and injuries (strep throat, ear infections, skin problems)
- School, sports, camp and work routine physicals
- Weight management and nutrition counseling
- Immunizations
- GYN exams—STD screenings
- Individual, family and group counseling
- Surveys
- Drug and alcohol testing, treatment, and education and prevention programs
- Crisis intervention
- Referral and follow up to medical specialists, community providers, agencies and hospitals
- Laboratory testing
- Prescriptions, medication management (including psychiatric medications)
- Psychotherapy, psychiatric and medication evaluations
- Pregnancy tests, screenings, options counseling and appropriate referrals

HSC's Dr. Robert E. Appleby School Based Health Centers
Registration Form
 NHS BMHS Briggs

Please complete all information on the front and back of this registration form. You must sign and date it in order for your student to receive services from the School Based Health Centers. If a student is 18 or older, he/she can sign his/her own registration form.

Grade: _____ Date of Birth: _____

Student's Name: _____ Sex: F M

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell phone: _____ Work Phone: _____

Emergency Contact Person:

Contact Name: _____ Phone #: _____ Relationship: _____

Contact Name: _____ Phone #: _____ Relationship: _____

Ethnicity of student (Per Federal OMB Guidelines): Please circle one.

Hispanic/Latino(a) Not Hispanic/Not Latino(a)

Race of student (Per Federal OMB Guidelines): Please circle one.

White Black AmIndian/Alaska Native Native Hawaiian or other Pacific Islander Asian

If Race of student is NOT listed above, kindly write in here: _____

Mother's Name _____ Daytime phone # _____

Father's Name _____ Daytime phone # _____

If not parents, whom do you live with? _____

Please indicate your relationship to student: Guardian Other

Source of Medical Care:

Who is your child's doctor/clinic: _____ Phone: _____

Where do you usually bring your student for medical care?

<input type="checkbox"/> Community Health Center	<input type="checkbox"/> Hospital Clinic/Outpatient	<input type="checkbox"/> Urgent Care Clinic
<input type="checkbox"/> Emergency Room	<input type="checkbox"/> Military Clinic	<input type="checkbox"/> Mobile Van
<input type="checkbox"/> Health Department Clinic	<input type="checkbox"/> Private MD	<input type="checkbox"/> None
	<input type="checkbox"/> School Based Health Clinic	<input type="checkbox"/> Other

STUDENT MEDICAL HISTORY (CONTINUED)

Family Health History:

Please check below if any of your child's relatives (i.e., Parents, brother/sisters, aunts, uncles, or grandparents) have/had any of the following illnesses and note which relative had them:

Illness	Relative	Explanation
<input type="checkbox"/> Diabetes, Endocrine Disorder	_____	_____
<input type="checkbox"/> Cancer	_____	_____
<input type="checkbox"/> Heart problem, Vascular Disease/Stroke	_____	_____
<input type="checkbox"/> High Blood Pressure	_____	_____
<input type="checkbox"/> Blood Disorders including Anemia/Thalessemia	_____	_____
<input type="checkbox"/> Respiratory Problems including Asthma	_____	_____
<input type="checkbox"/> Mental Illness	_____	_____
<input type="checkbox"/> Alcohol/Drug Problems	_____	_____
<input type="checkbox"/> Infections (TB, HIV, AIDS)	_____	_____
<input type="checkbox"/> Death Under the age of 50	_____	_____
<input type="checkbox"/> Liver/Kidney Problems	_____	_____

I have read the materials supplied to me regarding the services of the Health Centers and give permission to the above named student to obtain medical and/or mental health services offered at The Dr. Robert E. Appleby Health Centers (REAHC) while he/she is in school. Furthermore, I give permission to the Health Centers to release information regarding treatment and/or services to insurance providers for the purpose of billing, if applicable. I authorize insurance payments to be made directly to The Dr. Robert E. Appleby Health Centers for services provided.

Name of person completing this form

Date

Relationship to Student

HSC's DR. ROBERT E. APPLEBY SCHOOL BASED HEALTH CENTERS At:
Norwalk, Brien McMahon, Briggs High Schools'

INSURANCE VERIFICATION

- Please provide a copy of your current Insurance Card(s), Medicaid Card, Medicaid Managed Care Plan Card and any claim form(s) your insurance carrier requires.
- Type of insurance (check all that applies and complete information below on your child's coverage.)

Child's Name: _____ Date of Birth: _____ Sex: _____

INSURANCE:

Primary Insurance:

Carrier Name: _____

Address: _____

Phone Number: _____

Policy Number: _____ Group Number: _____

Effective Date of Coverage: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____

Employer: _____

Phone Number: _____

Does the child have Medicaid? Yes No

If yes, Medicaid #

Have you enrolled in Medicaid Managed Care? If yes, indicate below the name of the Plan.

I authorize the release of any medical information or other information necessary to process appropriate claims for health insurance for covered services under my policy. I also authorize the payment of medical benefits to the School Based Health Center.

Signed: _____ Parent Guardian Other

Date: _____