Foothill Community Health Center

Dear Parent/Guardian:

Foothill Community Health Center (FCHC) has partnered with the East Side Union High School District (ESUHSD) to establish a school-based health center located at your child's school. Our health and wellness center offers comprehensive primary medical, dental, vision, and behavioral health services to students, families, and the community. To learn more about FCHC and access our enrollment forms online, please visit our website at www.sjffcc.org.

Please note: In order for your child to gain access to any of our services, parent and/or guardian MUST complete the FCHC enrollment form and return it to your child's school health center or school main office.

Our health and wellness services include, but are not limited to:

- ***Medical***
  - Annual Physical Examination and Sports Physicals
  - Immunizations & TB Screening
  - Health Education and Nutrition
  - Disease Prevention Services
  - Chronic Disease Management (e.g., diabetes, heart disease, asthma, and obesity)
  - Treatment of Minor Injuries and Sick Visits
  - Walk-In Visits
  - Specialty Care Referrals
- ***Behavioral Health/Counseling***
  - Understanding emotional issues (anxiety, depression)
  - Understanding problems in dating and peer relationships
  - Coping with major life changes (loss of a parent, attending a new school)
  - Developing self-esteem and confidence
  - Trusting and tolerance of others
  - Connecting to others and understanding isolation
  - Respecting others
  - Anger management
  - Bullying
- ***Dental and Vision Screenings with Follow Up Referrals***

Our school-based health and wellness center will provide the above services at **NO-COST** to students and children (up to age 18). You will **NOT** be billed for any services provided at our school-based health and wellness center. Only your insurance or your child's insurance will be billed. You will **NOT** be asked to pay for your child's services, even if your insurance company does not cover the services provided. You may receive an Explanation of Benefits (EOB) statement from your insurance company reporting what services were provided to you during your visit. Our staff will also contact you to assist with any public health insurance enrollment if your child is uninsured. If you have any questions, please contact our billing department at (408)729-4290.

Healthy Students, Success in School, and Community Involvement are priorities of Foothill Community Health Center. If you have any questions, please feel free to contact us at (408)729-4290.

Sincerely,

Salvador Chavarin, CEO
Foothill Community Health Center

Foothill Community Health Center

School Based Health Center - Clinic Enrollment Form

STUDENT INFORMATION

FIRST NAME:	**LAST NAME:**	
NAME OF SCHOOL:	**DATE OF BIRTH:**	**GRADE:**
GENDER: MALE ☐ FEMALE ☐	**Referred By (Optional):**	

PARENT (s) OR GUARDIAN INFORMATION

Name:	**DOB:**	Name:	**DOB:**
Address:		Address:	
City: Zip:		City: Zip:	
Home Phone: Cell:		Home Phone: Cell:	
EMAIL:		EMAIL:	
Relationship to child: (circle) Mother Father Guardian		**Relationship to child: (circle) Mother Father Guardian**	

INSURANCE INFORMATION

Does your child have health insurance? Yes ☐ No ☐

* If NO, are you interested in enrolling your child into a public health insurance program? Yes ☐ No ☐

Insurance Name (Medi-Cal, Healthy Families, SCFHP, Blue Shield, etc.):	
Policy Number:	**Policy Holder's Name:**

HEALTH ALERTS

Is your child being treated for any health issues?	☐ YES	☐ NO
If yes, please explain:		
Does your child have any known allergies to food, medications, or any vaccines?	☐ YES	☐ NO
If yes, please explain:		
Has your child had any serious reactions after receiving vaccinations in the past?	☐ YES	☐ NO
Has your child had seizures, nervous system problems, or history of Guillain Barre syndrome	☐ YES	☐ NO

PARENTAL CONSENT FOR TREATMENT

• I/We have read and understand the services offered at the Foothill Community Health Center - School Based Health Center as described below. I/We understand further that the services authorized by my/our signature on this form are simple, common or routine health care services, and treatment not limited to:

* Diagnosis and treatment of minor illnesses and first aid for minor injuries
* Short-term assistance with chronic illness management and referrals for on-going care
* Sport Physicals and Annual Exams (CHDP)
* Immunizations (required school vaccines, flu shots, etc.)
* Tuberculosis Screening and Testing
* Health Education and Nutrition Counseling
* Dental Screenings & Referrals
* Vision Screenings & Referrals
* Behavioral Health Counseling Services
* Specialty Referrals

• I UNDERSTAND NO STUDENT OR HIS/HER FAMILY WILL BE CHARGED DIRECTLY FOR SERVICES DELIVERED AT THE HEALTH CENTER.

• I/WE understand that this consent covers only those services provided at this clinic, and does not authorize services rendered at any other private or public facility that are not affiliated with Foothill Community Health Center

• I realize that the Health Center staff will coordinate with the student's primary care provider to ensure continuity of care and will refer ongoing care needs to the student's regular physician

• I/We understand that this consent form remains in effect until my enrollment at my child's school terminates, or until revoked in writing.

This student has my/our permission to receive all services offered at the School Based Health Center

EXCEPT those which I have specifically excluded below:

_____

Print Name of Parent or Guardian:	**Date:**
Signature of Parent or Guardian:	**Date:**

Rev. 7/2014

Foothill Community Health Center

MEDICAL RELEASE FORM

Medical records will be kept confidential. However, I/We acknowledge that the services for my child's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School-Based Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing her/him

I hereby authorize the School-Based Health Center staff and provider to exchange information concerning my child for the purpose of medical evaluation and treatment. I understand this consent will not expire until I revoke it or my child/ward is no longer enrolled in a school served by Foothill Community Health Center (School-Based Health Center.)

_____ _____
Student's Full Name Date

_____ _____
(Print) Name of Parent/Legal Guardian Date

_____ _____
(Signature) Parent/Legal Guardian Date

_____
Address of Parent/Legal Guardian (if different from student)