Parish Hill Middle/High School
304 Parish Hill Rd.
Chaplin CT 06235
860 455 9584

2025-2026 School-Based Health Center Enrollment Form

*Please complete **both** sides of the form and **return** to the School Social Worker*

Information:

Student: _____ DOB: _____ Grade: _____

Gender: □ Male □ Female □ Non-Binary □ Prefer not to say □ Other:_____

Language(s): _____

Race/Ethnicity: □ Hispanic/Latino ***OR*** □ Non-Hispanic/Non-Latino

□ American Indian/Alaskan Native □ Asian □ White □ Native Hawaiian/Pacific Islander

□ Black/African American ***AND/OR*** □ Other:_____

Guardian: _____

Best Phone: _____

Email:_____

Address: *(If different from student address)*

_____

Guardian: _____

Best Phone: _____

Email:_____

Address: *(If different from student address)*

_____

Household: *Who lives with student*

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____

Name:_____

Relationship:_____

If needed, write additional household members on back

Total number of dependents in the household *(including student)*:_____

Total monthly household income:_____

Insurance:

□ Husky A □ Husky B □ Title 19 State Medicaid □ Private/Commercial
□ Uninsured

Providers: *All relevant outside providers (ex. Physician, therapists, med provider, family counselor, outside program, etc)*

Name: _____ Phone:_____

Location:_____

Services provided:_____

Name: _____ Phone:_____

Location:_____

Services provided:_____

Name: _____ Phone:_____

Location:_____

Services provided:_____

Name: _____ Phone:_____

Location:_____

Services provided:_____

Is your student currently in counseling? □ Yes □ No

Does your student have a history of counseling? □ Yes □ No

Dates:_____

Reason for end of service:_____

Additional important information regarding your student's mental/physical health:

_____

_____

_____

_____

CONTINUE ON NEXT PAGE

Check yes or no, providing explanations for 'yes' answers

Medical/Mental History	No	Yes	If yes, explain
Anxiety/depression/mood disorders			
Seizures/fainting			
ADHD/ADD/learning disorder			
Autism/Aspergers			
Weight problem/eating disorder			
Self-harm/suicidal ideations			
Substance use			
Sleep problems			
Behaviors			
Academic failure			
Headache/migraines			
Asthma*			
Hearing			
Vision			
Loss/grief			
Traumatic experience(s)			
Divorce/Parent death			
Alternative/Alternate living arrangements			
Allergies			
Diabetes/thyroid/endocrine			
Family History: ADHD/ADD, Substance use, anxiety, other mental health (specify)			
Hospital stays related to mental health			

**If answered yes, please provide a copy of your student's asthma action plan*

CONTINUE ON NEXT PAGE

Medications: *Please list all medications relevant to the above medical/mental history*

Name:_____ Frequency:_____
Purpose:_____
Name:_____ Frequency:_____
Purpose:_____
Name:_____ Frequency:_____
Purpose:_____

If needed, write additional medications on back

- I give permission for my child to receive services offered by the School-Based Health Center at Parish Hill Middle/High School. I understand that these services are confidential, except in life-threatening situations or as otherwise required by law.
  Initial: _____
- I authorize the exchange of information with appropriate school personnel when necessary to support my child's health and safety. I understand that confidential health records will not be shared without my consent, in accordance with the law.
  Initial: _____
- I allow student services staff to share information related to treatment and services with the Parish Hill School Nurse.
  Initial: _____
- I have reviewed the materials about the School-Based Health Center and give full permission for my child to receive all available services during school hours, as needed.
  Initial: _____
- I acknowledge receipt of the Health Center's "Privacy Notice" and understand I may contact the Center with questions.
  Initial: _____

Parent/Guardian: _____ Date: _____
(Signature)

Parent/Guardian: _____ Date: _____
(Print)