



School Health Services
Harrisburg School District
School-based Health and Dental Program



Dear Parents,

The Harrisburg School District in partnership with Highmark Foundation and Hamilton Health Center will be offering a preventive health and dental program this year for students. Students will be able to receive: (1) health assessment/ physical examination and/ or sick visits and/or (2) preventative dental care. Insurance may be billed for services but no child will be turned away based on lack of insurance coverage or ability to pay.

To enroll you child in the program, please sign and date the form below. Please fill this form out completely in black ink.

Permission is given for _____ / / / / **to receive**
 (Print first and last name of student) (Birth date) (School) (Grade) (Homeroom)

1. Dental exam, fluoride, sealants, x-rays, cleaning.
2. Health assessment and physical examination, sick visits.

I authorize my insurance benefits to be paid directly to Hamilton Health Center. .

- YES** - I would like to receive dental services for my child
- YES** - I would like to receive a physical examination for my child.
- Please notify me of the appointment date and time for my child’s dental services and/or physical exam.
- YES** - I give my permission to have my child transported to the school-based clinics.
- YES** – I give my permission for my child to participate in Health Education Classes.
- NO** - I would **NOT** like to receive dental services for my child. **I will provide documentation of an examination from my private dentist.**
- NO** - I would **NOT** like to receive a physical examination for my child. **I will provide documentation of a dental examination from my private doctor.**

To the best of my knowledge, all of the information I have provided is correct. If my child has any future change in his/her medical history, I will inform the medical doctor or dentist.

Print name of Parent/ Legal guardian	<u> X </u> Signature of Parent/ Legal Guardian (To allow child to receive dental/medical services)
Print name of insured (parent/guardian)	<u> X </u> Signature of Parent/Legal guardian (To allow Harrisburg School District to receive insurance benefit s)
Insurance Company	Group # (from insurance card)
Date	I.D. # (from insurance card)

If you have questions or concerns regarding the health assessments/ physical exams/dental , please call 703-1268.



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Please fill out form completely:

Child's Name _____ Birth Date: _____ Race: _____

Address: _____ Sex: M or F SS#: _____

School: _____ Grade: _____ Homeroom: _____

Parent/ Legal Guardian: _____ Phone: (home) _____ - _____
(cell) _____ - _____

Primary Language: English, Spanish Other: _____ (work) _____ - _____

Emergency Contact _____

Child's Medical History

Child's Primary Care Physician: _____

This child takes the following medicines: _____

This child has these allergies (to medicines, foods, latex, etc.): _____

Has your child ever had any of these conditions? Please circle YES or NO.

Anemia	Yes	No	Hepatitis	Yes	No
Asthma	Yes	No	HIV Infection	Yes	No
Prolonged Bleeding	Yes	No	Physical Disability	Yes (list: _____)	No
Cancer	Yes	No	Mental Disability	Yes (list: _____)	No
Diabetes	Yes	No	Emotional Disability	Yes (list: _____)	No
Endocrine Problems	Yes	No	Seizures	Yes	No
Heart Disease	Yes	No	Tuberculosis Test	Yes (pos or neg)	No
Heart Murmur	Yes	No	Rheumatic Fever	Yes	No
Chest Pains	Yes	No	Hospitalization	Yes	No
Surgery	Yes	No	If yes, when/ why:	_____	
If yes, when/ why:	_____		Other:	_____	

If you answered yes to any of the above, please give details here:

Dental History

Has your child ever been to the dentist before? Yes No Date of last appointment? _____

Has your child ever injured his/her mouth/teeth? Yes No If yes, how and when? _____

Does/did your child suck their thumb? Yes No

How many times does your child drink soda/sugary drinks/fruit juices in a day? _____

What information would you like to learn about teeth? _____

CHIEF COMPLAINT: _____