2024 - 2025
Pendleton School Based Health Center

Student's Legal Last Name: _____ **First Name**: _____

Preferred Name:_____ **Pronouns:** _____

Grade Level: _____ **Birthdate**: _____ **Age:** _____ **Phone Number:** _____

Gender: ☐ Male ☐ Female ☐ Non-Binary **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Don't Know ☐ Decline to answer

Race: ☐Asian ☐ Black ☐ Native American ☐ Pacific Islander ☐ White ☐ Other ☐ Don't Know ☐ Decline to answer

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

Primary Care Provider:_____**Last Visit Date:**_____

Dental Provider:_____**Last Visit Date:**_____

Vision Provider: _____ **Pharmacy:** _____

Parent/Guardian Emergency Contact Information

Name: _____ **Relationship**: _____ **Phone Number**: _____

Name: _____ **Relationship**: _____ **Phone Number**: _____

****Please send a copy of your insurance card and/or complete the Insurance Information form****

Consent for Services

I give permission for the Pendleton School Based Health Center (SBHC) to provide medical and/or mental health services to the above-named individual*. I understand the following types of services are provided through the SBHC: Routine physical exams (including sport's physicals), assessment, diagnosis, and treatment of illness and injury, vision and dental screenings, routine lab tests, immunizations, health education, counseling, prescription medications, over the counter medications, mental health services, and referral for health care services not provided by the SBHC. I understand that these services may be offered in person or through electronic communications such as two-way video or voice phone call.

I understand that the SBHC is a collaboration between SBHC staff (including employees from Umatilla County Public Health and Community Counseling Solutions) and Pendleton School District (PSD) Staff and that information regarding student well-being may be shared between SBHC and PSD staff for the safety, health, and overall academic success of the above-named individual. I also authorize and give permission to the SBHC to contact the above-named individual's personal care physician to share medical information regarding ongoing medical needs.

I authorize the release of any medical and protected health information necessary to process this claim and authorize payment of medical benefits for services by the Pendleton School Based Health Center. Insurance will be billed for services provided at the School Based Health Center. Any services provided outside of the School Based Health Center (such as pharmacy, radiology, or labs) are the responsibility of the parent and/or guardian.

Pendleton School Based Health Centers are required by law to maintain the privacy of your health information. A copy of the Notice of Privacy Practices is available at ucohealth.net/sbhc I understand the SBHC has the right to change this Notice at any time. A current copy is available upon request by contacting the School Based Health Center.

I have read the above information and have had the opportunity to ask questions. This consent will remain in effect for one year from the date of signature. I understand I may revoke this consent at any time by providing a written notice to SBHC.

Signature: _____ **Relationship:** _____ **Date:** _____

*We support and encourage parental involvement in decisions about a child's health care. Oregon State Law requires the signature of a parent or guardian for medical treatment for students less than 15 years of age with the exception of family planning information and sexually transmitted infections. Oregon State Law requires the signature of a parent or guardian for mental health services, including drug and alcohol issues, if the child is less than 14 years of age. ORS 109.610, ORS 109.640, ORS 109.675.

Insurance Information

School Based Health Centers are funded through third-party insurance, Medicaid, grants, and local support. Providing us with your insurance information allows us to bill your insurance and continue to provide the services to as many students as possible.

Families with no health insurance or who do not provide insurance information are referred for screening to see if they qualify for the Oregon Health Plan or other insurance programs. This coverage could fully insure your child for medical, dental, and emergency services. We strongly encourage you to apply for this valuable coverage.

If your insurance company sends a payment check directly to you, please endorse it to the Umatilla County Public Health Department and bring or send it to your school health center.

If your insurance company does not pay for all or part of the cost you are not responsible for any out-of-pocket expenses for services received at the School-Based Health Center.

Today's Date: _____

Student's Last Name: _____ **First Name:** _____ **MI:** _____

Birthdate: _____

****Please let us make a copy of your insurance card or bring us a current copy****

Oregon Health Plan / EOCCO

Policy/ID Number: _____

Private Insurance

Name of Insurance Company: _____

Insurance Company Phone Number: _____

Policy / ID Number: _____ **Group Number:** _____

Name of Policy Holder: _____ **Birthdate:** _____

Relationship to Student: _____

Does the student have secondary insurance? ☐ Yes ☐ No

Name of Secondary Insurance: _____

Insurance Company Phone Number: _____

Policy / ID Number: _____ **Group Number:** _____

Name of Policy Holder: _____ **Birthdate:** _____

Relationship to Student: _____

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Health History Questionnaire

Student Name:_____ Birthdate:_____

Allergies to medications/foods/insects:

Name	Reaction

List prescribed medications and over-the-counter medications:

Name of Medication	Strength/Dose	Frequency Taken

Please check if the student has had any of the following:

- ❑ Allergies
- ❑ Anemia
- ❑ Birth Defects
- ❑ Bleeding Disorders
- ❑ Cancer
- ❑ Concussion or loss of consciousness
- ❑ Developmental Disabilities
- ❑ Diabetes
- ❑ Drug and/or Alcohol Abuse
- ❑ Eating Disorder
- ❑ Gallbladder Problems
- ❑ Headaches
- ❑ Hearing Problems
- ❑ Heart Issues/Disease
- ❑ Hepatitis B, and/or C
- ❑ Other:_____
  _____
- ❑ High Blood Pressure/Low Blood Pressure
- ❑ Kidney Disease
- ❑ Lung Disease/Asthma/RAD
- ❑ Mental Illness/Anxiety/Depression
- ❑ Mononucleosis
- ❑ Obesity/Overweight
- ❑ Rheumatic Fever
- ❑ Seizures
- ❑ Stroke
- ❑ Sudden weight Loss
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Vision Problems
- ❑ Student Adopted

Student Surgeries/Hospitalization:_____

_____

_____

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Family History Questionnaire

Student Name:_____ Birthdate:_____

Illness/Condition	Mother	Father	Sister	Brother	Grandmother	Grandfather	Notes
Family History Unknown							
Alcohol Abuse							
Allergies							
Anemia							
Anxiety							
Asthma							
Birth Defects							
Bleeding Disorder							
Cancer							
Developmental Disabilities							
Depression							
Diabetes							
Drug Abuse							
Eating Disorder							
Gallbladder Problems							
Headaches							
Hearing Problems							
Heart Attack							
Heart Issues							
High Blood Pressure							
High Cholesterol							
Kidney Problems							
Lung Problems							
Mental Illness							
Obesity							
Seizures							
Stroke							
Thyroid Problem							
Tuberculosis							
Vision Problems							
Other							