

**Linkages to Learning School-Based Health Center  
Gaithersburg Elementary School**

**Enrollment Form**

*Please complete both sides of form*

**Student ID #**

<b>Child's Name:</b> _____	<b>Grade:</b> _____
<b>Birthdate:</b> _____	<b>Social Security #</b> _ _ - _ - _ - _ <b>Sex:</b> _____ <b>Race:</b> _____
<b>Address:</b> _____	<b>Home Phone:</b> _____
<b>City:</b> _____	<b>State:</b> _____ <b>Zip Code:</b> _____
<b>Country of Birth:</b> _____	<b>Primary Language:</b> _____
<b>Parent/Guardian:</b> _____	<b>Work Phone:</b> _____
<b>Non Parent Emergency Contact:</b> _____	
<b>Contact's Relationship to Child:</b> _____	<b>Contact's Phone:</b> _____

I grant permission for my child, \_\_\_\_\_, to enroll in the Linkages to Learning School-Based Health Center. I consent to his/her receiving services which can include complete physical examinations, treatment for chronic and acute health problems, limited diagnostic tests, dental evaluation, health education, mental health assessment (up to 3 sessions), and case management.

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the Health Center.
- Before a child receives on going mental health counseling, individually or in groups, additional parental permission will be obtained by Health Center staff.
- All Health Center records are confidential and only the Health Center providers will have access to a child's Health Center records and information.
- If a child has health insurance, the insurer will be billed for services given in the Health Center and the insurer will be provided with required information about the child's health status.
- Services in the Health Center at Gaithersburg Elementary School will be provided by staff from Montgomery County Department of Health and Human Services; Catholic University of America; Children's National Medical Center; and GUIDE Program, Inc.

I understand the description of services and policies of the Health Center as stated above and give permission for my child to enroll and receive services in the Linkages to Learning School-Based Health Center. I understand that this permission can be withdrawn at any time by submitting notice in writing.

**Signature of Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Relationship to Student:** \_\_\_\_\_

**Linkages to Learning School-Based Health Center  
Health Insurance Information**

**No child will be denied services because of inability to pay**

*The following information will be used to bill your insurance provider when appropriate. Please complete one of the boxes below.*

**If your child has Medical Assistance, please complete the following information:**  
Child's Medical Assistance Number: \_\_\_\_\_  
Child's Medical Assistance Doctor: \_\_\_\_\_  
Telephone No: \_\_\_\_\_  
Child's Managed Care Organization: \_\_\_\_\_

**If your child has private health insurance, please complete the following information:**  
Policy Holder: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_  
Social Security Number of Policy Holder: \_\_\_\_\_  
Insurance Company Information:  
Name of Insurer: \_\_\_\_\_  
Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Telephone No: \_\_\_\_\_  
Group Number: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Child's Doctor: \_\_\_\_\_ Telephone No: \_\_\_\_\_

**If your child is enrolled in Care For Kids, please complete the following information:**  
Child's Care Provider: (check one)  
Community Clinic   
Kaiser   
Private Doctor  Name of Doctor \_\_\_\_\_ Phone No \_\_\_\_\_

**If your child has no health care coverage, please indicate so by checking here: ( )**  
**Please check the appropriate space indicating your approximate family income:**  
0-\$10,000 \_\_ \$11 - 20,000 \_\_ \$21 - 30,000 \_\_ \$31 - 50,000 \_\_ \$51,000 & above \_\_  
**Please indicate number of people in your household: Adults \_\_\_\_\_ Children \_\_\_\_\_**

**PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE!**