# Student Medical History 2024-2025

Student Name_____ Grade_____

School Botelle Elementary Teacher _____

## Student Information

| Is the student allergic to or has he/she had a reaction to: | Y | N |
|---|---|---|
| Any foods | | |
| Any medicines (Penicillin or other antibiotic) | | |
| Local Anesthetics | | |
| Latex | | |
| Please explain any allergies: | | |
| Has the student had any serious injuries or sports-related injuries? | | |
| Has the student ever been hospitalized overnight? | | |
| Has the student had any surgery? | | |
| Is the student taking any medication now? | | |
| If yes, please list: | | |
| | | |
| Does the student have any heart problems, such as a heart murmur or congenital heart defects? | | |
| If yes, is an antibiotic needed prior to dental treatment? | | |
| Does the student have any other health problems? | | |
| Is the student currently seeing a physician for any problems? | | |
| Has there been any change in the student's health during the past year? | | |
| Does the student have any behavior or learning problems? | | |
| **Dental Health Questions** | | |
| Does the student have his/her teeth cleaned at least once a year? | | |
| Are any of the student's teeth causing him/her pain? | | |
| Do the student's gums bleed while brushing or flossing? | | |

**OFFICE USE:**

_____

PROVIDER SIGNATURE DATE

## Student Information

| |
|---|
| **Physician's Name** |
| Physician's Address |
| Physician's Phone |
| Date of Last Physical Examination |
| **Dental History** |
| Is this the student's first dental visit? Circle one Yes No<br>**If no, please complete the following :** |
| 1) Name of Family Dentist Seen |
| 2) Dentist's Address /Phone |
| 3) Date of Last Dental Visit |
| Was the student seen in the school dental program in prior years? Circle One Yes No |
| Has the student ever been seen at the Brooker Memorial Dental Center? Circle One Yes No |

## Has the student had any of the following illnesses or conditions?

| Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|
| ADHD / ADD | | | Hepatitis | | |
| Anemia or blood disorders | | | Mental illness/ depression | | |
| Asthma | | | Rheumatic fever or heart disease | | |
| Autism | | | Seizures | | |
| Bladder or kidney infections | | | Tuberculosis | | |
| Cancer | | | Thyroid disease | | |
| Diabetes | | | Ulcer/digestive problems | | |
| Endocrine Gland disease | | | | | |
| | | | | | |
| | | | | | |

Does the student have any disease, condition or problem not listed above?
If yes, please explain_____

_____

Other Notes or Information_____

X_____

PARENT/GUARDIAN SIGNATURE DATE

# Student Information/Permission 2024-2025

Last Name_____ First Name _____MI_____

Mailing Address_____City_____State_____ Zip_____

Date of Birth: _____ Sex: _____M _____F

Name of Legal Guardian_____ Relationship to Student _____

*Email address*_____ Telephone_____

Address if different than student's _____

Student's Insurance: _____HUSKY _____Private (Insurance Company_____) _____No Dental Ins

Subscriber's name:_____ Employer_____

Subscriber's DOB:_____ Insurance Address _____

Student's or Subscriber's ID and Group# (HUSKY ID # from gray Connect card) _____

***Please attach a copy of your dental insurance card (front and back)***
***I give permission for Brooker Dental to bill my insurance: yes_____ No_____***
***Most insurance covers cleanings one per 6 months, please check your next appointment date with your provider***

| | Y | N |
|---|---|---|
| I give permission for my child to be treated in the school and receive services deemed necessary by the dental staff of Brooker Memorial. This includes Dental Cleanings, Oral Health Screening, Fluoride and application of Sealants. | | |
| I certify that the health information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student's health. | | |
| I agree that messages can be left for me on the telephone number provided in the Student Information section of this form. | | |
| I agree to ensure that my child receives any follow-up treatment outlined by the dental hygienist or dentist. | | |
| **If applicable, Release of Information and Payment Authorization:** **I authorize the release of any medical or other information necessary to process my child's insurance claim. I also authorize payment of insurance dental benefits to Brooker Memorial for services provided.** | | |
| **Authorization for Exchange of Health & Education Information:** I hereby authorize Brooker Memorial to exchange health and education records with my child's school district for the purpose of providing care and treatment to my child. | | |
| This authorization is valid while my child is enrolled in Botelle Elementary. I understand I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand if I refuse to sign, such refusal will not interfere with my child's ability to obtain dental care. I agree that a copy of this authorization is as valid as the original. I hereby authorize Brooker Memorial to communicate with my child's dentist if I have listed him/her on this form. My child's dentist may be notified by Brooker Memorial about needed follow up care or other relevant dental information, including date of their school visit with Brooker's hygienist (for coordination of treatment and billing) | | |
| I give permission for Brooker Memorial to use my child's name and/or photograph(s) for publicity purposes, including printed publications, internal bulletin boards, FaceBook, Brooker website, Foundation For Community Health publications and other social or electronic media. I understand that no compensation or other remuneration will be given for use of any photo or information used. | | |
| **Consent and Acknowledgement of Privacy Practices:** I consent to the use and disclosure of my child's protected health information by Brooker Memorial (Brooker) to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain healthcare operations. as long as such information is used or disclosed in accordance with Connecticut and Federal law. I understand that information regarding how Brooker will use and disclose my child's information can be found in Brooker's Notice of Privacy Practices. I understand that this consent is effective for as long as my child is enrolled in Botelle Elementary. | | |
| By signing below, I understand and acknowledge the following: 1) I have read and understand this consent;, and 2) I have received Brooker's Notice of Privacy Practices currently in effect or have access to a copy at www.brookermemorial.org. | | |

PRINTED NAME OF LEGAL GUARDIAN X _____

X_____DATE_____
SIGNATURE