Bakersfield City School District
School Health & Neighborhood Support Program

B.C.S.D. Wellness Center & ACE Eyecare Inc.
Enrollment Packet

For Office Use Only
SID & School

Student Name: _____ **D.O.B.:** _____ / _____ / _____

MEDICAL/HEALTH CARE SERVICES:

☐ **YES**, I consent for my student to receive **medical/health care,** with or without my presence**,** at B.C.S.D. Wellness Centers including routine Well Child Exam/Physical (periodic wellness physicals) appropriate immunizations, and treatment for illness or injury including medications, unless emergency services are needed. *(see program description for more details)*

☐ **NO**, I do not consent for my student to receive **medical/health care** at B.C.S.D Wellness Centers.

BEHAVIORAL/MENTAL HEALTH SERVICES:

☐ **YES**, I consent for my student to receive **behavioral/mental health services**, with or without my presence, at B.C.S.D. Wellness Centers, including social skills, group therapy, individual therapy, or family therapy. *(see program description for more details)*

☐ **NO**, I do not consent for my student to receive **behavioral/mental health services** at B.C.S.D. Wellness Centers.

VISION SERVICES:

☐ **YES**, I consent for my student to receive **vision services,** with or without my presence**,** provided by ACE Eyecare, Inc. at B.C.S.D. Wellness Centers, which may include comprehensive eye examinations including dilation, fitting and dispensing of vision corrective wear (glasses). *(see program description for more details)*

☐ **NO**, I do not consent for my student to receive **vision services** provided by ACE Eyecare, Inc. at B.C.S.D. Wellness Centers.

TRANSPORTATION:

☐ **YES**, I consent for my student to be **transported/accompanied** by a B.C.S.D. employee to and from medical, dental, vision, behavioral/mental health services. I, the parent/guardian of the above named student, release Bakersfield City School District, its Board Members, employees, and authorized agents and representatives from any and all liability related to personal injury or damage resulting from the transportation of my child to and from B.C.S.D. Wellness Centers and related services.

☐ **NO**, I do not consent for my student to be **transported/accompanied** to or from B.C.S.D. Wellness Centers and related services.

ADDITIONAL CONSENT

☐ I consent to be contacted by B.C.S.D. Wellness Centers via email, phone, voicemail, and/or text message.

By signing this consent, I agree to the submission of claims to my insurance carrier for services provided to my student by B.C.S.D. school nurses, speech therapists, school psychologists, school social workers, ACE Eyecare Inc., and B.C.S.D. Wellness Center staff. I understand there will be **no cost to me for services provided to my student** by B.C.S.D. Health Staff. I assign all medical benefits to which I am entitled to ACE Eyecare Inc & B.C.S.D. I authorize the said assignee to release all information necessary to secure payment. This assignment will remain in effect until revoked by me in writing. I have read and agreed to B.C.S.D. & Ace Eyecare Inc, Notice of Privacy Practices, and Patient Consent for the Use and Disclosure of Protected Health Information as explained in the Program Description found in the Guide for Parents & Students and available at the B.C.S.D. Wellness Centers.

_____ _____

Parent/Guardian Signature **Today's Date**

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B.C.S.D. Wellness Centers & ACE Eyecare Inc.
PATIENT INFORMATION

Student Name: _____ D.O.B.: _____ / _____ / _____

Address: _____ Zip Code**:** _____

Student's Social Security Number: _____

Insurance Name: _____ Insurance Number: _____

Parent/Guardian Name: _____D.O.B: _____ / _____ / _____

Relationship to Student: _____ Parent/Guardian Last 4 of SS# _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email address: _____

Preferred Method of Communication (circle): Phone Call Text Messages Email

Emergency Contact Name: _____ Phone Number: _____

STUDENT INFORMATION:

Regular Doctor or Clinic: _____ Phone Number: _____

Address: _____ Zip Code: _____

Date of student's last complete physical examination (head to toe): _____ / _____ / _____

**** Do you want a copy of the physical exam to go to regular medical doctor or clinic? YES NO**

Regular Dentist or Clinic: _____ Phone Number: _____

Address: _____ Zip Code**:** _____

Date of student's last routine dental check-up: _____ / _____ / _____

Regular Eye Doctor: _____ Phone Number: _____

Address: _____ Zip Code: _____

Date of student's last eye exam: _____ / _____ / _____

Preferred Pharmacy: _____ Location/Street Name: _____

_____ _____

Parent/Guardian Signature **Today's Date**

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HEALTH HISTORY

Student Name: _____ **D.O.B.** _____/_____/_____

CIRCLE "Y" for Yes or "N" for No:			**CIRCLE Who:**				
Alcohol/Drug Abuse	Y	N	Student	Brother	Sister	Parent	Grandparent
ADHD	Y	N	Student	Brother	Sister	Parent	Grandparent
Asthma	Y	N	Student	Brother	Sister	Parent	Grandparent
Anemia	Y	N	Student	Brother	Sister	Parent	Grandparent
Bed Wetting	Y	N	Student	Brother	Sister	Parent	Grandparent
Birth Defects	Y	N	Student	Brother	Sister	Parent	Grandparent
Blindness	Y	N	Student	Brother	Sister	Parent	Grandparent
Bone Problems	Y	N	Student	Brother	Sister	Parent	Grandparent
Cancer	Y	N	Student	Brother	Sister	Parent	Grandparent
Cataracts	Y	N	Student	Brother	Sister	Parent	Grandparent
Diabetes	Y	N	Student	Brother	Sister	Parent	Grandparent
Ear/Nose/Throat	Y	N	Student	Brother	Sister	Parent	Grandparent
Eye Problems	Y	N	Student	Brother	Sister	Parent	Grandparent
Glaucoma	Y	N	Student	Brother	Sister	Parent	Grandparent
Heart Disease	Y	N	Student	Brother	Sister	Parent	Grandparent
High Blood Pressure	Y	N	Student	Brother	Sister	Parent	Grandparent
High Cholesterol	Y	N	Student	Brother	Sister	Parent	Grandparent
Joint Problems	Y	N	Student	Brother	Sister	Parent	Grandparent
Kidney Disease	Y	N	Student	Brother	Sister	Parent	Grandparent
Lead	Y	N	Student	Brother	Sister	Parent	Grandparent
Liver Disease	Y	N	Student	Brother	Sister	Parent	Grandparent
Lung Disease	Y	N	Student	Brother	Sister	Parent	Grandparent
Migraine Headaches	Y	N	Student	Brother	Sister	Parent	Grandparent
Metabolic Disorders	Y	N	Student	Brother	Sister	Parent	Grandparent
Obesity	Y	N	Student	Brother	Sister	Parent	Grandparent
Retinal Detachment	Y	N	Student	Brother	Sister	Parent	Grandparent
Seasonal Allergies	Y	N	Student	Brother	Sister	Parent	Grandparent
Stomach Problems	Y	N	Student	Brother	Sister	Parent	Grandparent
Seizures	Y	N	Student	Brother	Sister	Parent	Grandparent
Skin/Acne	Y	N	Student	Brother	Sister	Parent	Grandparent
Stroke	Y	N	Student	Brother	Sister	Parent	Grandparent
Thyroid	Y	N	Student	Brother	Sister	Parent	Grandparent
Behavioral/Mental	Y	N	Student	Brother	Sister	Parent	Grandparent

Other Concerns: _____

_____

_____ _____

Parent/Guardian Signature **Today's Date**

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HEALTH HISTORY (continued)

Student Name: _____ D.O.B. _____/ _____/ _____

PLEASE MARK ANY ALLERGIES & LIST **CIRCLE REACTION**

- ☐ Medication(s)_____ mild moderate severe
- ☐ Food(s) _____ mild moderate severe
- ☐ Insect(s) _____ mild moderate severe
- ☐ None of the above

LIST YOUR STUDENT'S CURRENT & PAST MEDICATIONS (if extra space needed, please use the back of the page)

1. _____ CURRENT PAST
2. _____ CURRENT PAST
3. _____ CURRENT PAST
4. _____ CURRENT PAST

PREGNANCY HISTORY (WITH THIS CHILD)

Hospital Name and City of Birth: _____

Mother's Age (at time of pregnancy) _____ Child # 1 2 3 4 5 6 or _____

Prenatal medical Care during pregnancy? Yes No Did baby cry right away? Yes No

Drugs/Alcohol/Smoking during pregnancy? Yes No Premature Birth? Yes No

Duration of pregnancy? _____ months

Delivery: Normal Forceps Cesarean (planned / unplanned)

Birth Weight: _____ lbs. _____ oz. Birth Length: _____in.

VISION QUESTIONS:

Has your student ever had to wear an eye-patch? Yes No

Does your student currently wear glasses? Yes No

At what age did the student start wearing glasses? _____

TUBERCULOSIS (TB) RISK ASSESSMENT (check all that apply):

☐ Birth, Travel, or Residency in a country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe at least 1 month

☐ Immunosuppression, current or planned
- HIV Infection, organ transplant recipient, treated with TNF-alpha antagonist, steroids or other immunosuppressive medication

☐ Close contact to someone with infectious TB disease during lifetime.

☐ None of the above.

SCHOOL CONCERNS (please circle Yes or No):

Does your student have learning problems? Yes No Is your student in special classes? Yes No

Has your student repeated a grade? Yes No Does your student get into trouble often at school? Yes No

_____ _____

Parent/Guardian Signature Today's Date