

REGISTRATION FORM

School Based Health Program

Today's Date:				How were you referred to our program?			
PATIENT INFORMATION							
Student's last name:		First Name:		Middle:		Grade:	Social Security #:
Birth date:	Age:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F		Phone #	Allergies:		
Street address:		P.O. Box		City:	State:	Zip Code:	
Name of Parent/Legal Guardian:		Relationship to Student:		Date of Birth:	Social Security #		
Race (check boxes that apply): <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Black /African American <input type="checkbox"/> American Indian/ Alaskan Native <input type="checkbox"/> White <input type="checkbox"/> More than one Race <input type="checkbox"/> Unreported/Refuse to Report							
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic							

INSURANCE INFORMATION			
<input type="checkbox"/> Commercial <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other Insurance <input type="checkbox"/> No Insurance			
Primary Insurance Company:	Card Holder's Name:	Group #:	Policy #:
Secondary Insurance:	Card Holder's Name:	Group #:	Policy #:
Name of Student's Primary Care Provider _____		Primary Care Provider's Phone # _____	
Address of Primary Care Provider _____			

IN CASE OF EMERGENCY		
<p>We require the name, address, phone number and/or cell phone number of 2 contacts who are not family members.</p>		
_____	_____	_____
(Name of First contact)	(Address)	(Phone and/or Cell #)
_____	_____	_____
(Name of Second contact)	(Address)	(Phone and/or Cell #)
Signature of Parent/Guardian : _____		Date: _____

School Based Health Center

Consent for Health Services Form

The following services will be provided to your child at the School-Based Health Center:

- 1) Comprehensive physical exams, including those for school sports and working papers
- 2) Lab test, when necessary, to detect illness or infection (i.e., strep throat)
- 3) Immunizations
- 4) First aid and assessment of acute illness, injuries and emergency care
- 5) Assessment and treatment for acute and chronic conditions and minor injuries
- 6) Prescriptions and medication administration
- 7) Referrals to an outside agency for services not provided at the School-Based Health Center
- 8) Nutrition counseling
- 9) Health education counseling
- 10) Mental Health Services

I hereby give consent for, _____ to receive health care services provided by the professional staff of the School-Based Health Center.

I further give consent to the staff of the School Based Health Center to examine my child's full medical and school records, including any information that may assist them in helping my child. In addition, if necessary, you may contact our family physician or any other healthcare providers to share information regarding my child's treatment and you may exchange medical information as needed with the school nurse for coordination of care purposes.

I further give consent to the staff of the School Based Health Center to obtain copies of my child's most recent physical exam and immunization records from their Primary Care Provider.

I hereby give consent to receive Comprehensive Physical Exam by the professional staff of the School Based Health Center.

I also authorize the release of any medical information necessary to process any insurance claim to my designated insurance carrier and made payable directly to Whitney M. Young Jr. Health Services /School-Based Health Program.

I understand that when necessary every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment or advise about drug abuse, alcoholism, sexually transmitted disease, reproductive health or outpatient mental health services.

All care provided will be in collaboration with your child's Primary Care Provider.

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of Whitney M. Young Jr. Health Services Privacy Practices, Patient Bill of Rights, Patient responsibilities and Programs and Services available to me and my family.

The staff of the School-Based Health Center considers parental/guardian involvement very important. Accordingly, the staff will encourage every student to involve his/her parent/ guardian in counseling and medical care decisions. We encourage parents/ guardian to visit or call the Center at any time.

Signature: _____ **Date:** _____

Relationship: _____