Upstate Family Health Center, Inc.

SCHOOL BASED HEALTH CENTER

ENROLLMENT FORM

Student Name			Date of Birth		Sex ❑ Female ❑ Male
Phone Number		Cell Number		Social Security	
Address	Apt	City	State	Zip	Country
Mother's Name:		Father's Name:			
Mother's Date of Birth:	Mother's Maiden Name		Father's Date of Birth:		
Legal Guardian: ❑ Dad ❑ Mom ❑ Shared ❑ Other (Explain)					
Emergency Contact Name:	Relationship to Student:		Phone Number		

Please check only one box below which best fits your needs

❑ My child regularly goes to another doctor or clinic for health care. I would like the school based health center to work with my child's doctor/clinic to keep my child healthy Doctor's name and address: _____

❑ My child does not have a regular doctor or clinic. I would like the school based health center to provide health care as necessary to keep my child healthy.

CONSENT TO TREAT - PLEASE READ AND SIGN BELOW.

I GIVE CONSENT FOR MY CHILD TO RECEIVE HEALTH CARE SERVICES PROVIDED BY THE STAFF AT THE SCHOOL BASED HEALTH CENTER. I UNDERSTAND THAT I MAY OR MAY NOT BE PRESENT FOR MY CHILD'S MEDICAL APPOINTMENT. THE STAFF OF THE SCHOOL-BASED HEALTH CENTER CONSIDERS PARENTAL INVOLVEMENT VERY IMPORTANT. IN ORDER TO PROVIDE OPTIMAL HEALTH CARE TO YOUR CHILD, IT MAY BE NECESSARY FOR THE SCHOOL BASED HEALTH CENTER STAFF AND SCHOOL NURSE TO REGULARLY COMMUNICATE AND SHARE MEDICAL AND HEALTH RELATED INFORMATION.

_____ _____

SIGNATURE OF PARENT/GUARDIAN **DATE**

HEALTH INSURANCE INFORMATION

Is student covered by health insurance? ❑ Yes ❑ No

Primary Insurance & Address			Policy #
Name of Policy Holder:	Date of Birth		SSN
Employer of Policy Holder:	Relationship of Patient to Insured:		
Secondary Insurance & Address			Policy #
Name of Policy Holder:	Date of Birth		SSN
Employer of Policy Holder:	Relationship of Patient to Insured:		

MY INSURANCE COVERS IMMUNIZATIONS. ❑ Yes ❑ No

BILLING CONSENT - INSURANCE AUTHORIZATION AND ASSIGNMENT

***ASSIGNMENT AND RELEASE*: I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO UPSTATE FAMILY HEALTH CENTER. I ALSO AUTHORIZE UPSTATE FAMILY HEALTH CENTER TO RELEASE ANY INFORMATION REQUESTED BY INSURANCE COMPANIES INCLUDING MEDICAL, SURGICAL, DRUG, ALCOHOL, AND/OR PSYCHIATRIC INFORMATION. RELEASE OF HIV/AIDS INFORMATION MAY REQUIRE FURTHER AUTHORIZATION.**

_____ _____

SIGNATURE OF PARENT/GUARDIAN ***DATE***