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: ☐ M ☐ F	Phone #	Name of Parent/Legal Guardian:	
Street address:		P.O. Box	APT #	Relationship	
City:		State	Zip	Medicine Allergies / Chronic Conditions	

Race (check boxes that apply): ☐ Asian ☐ Native Hawaiian ☐ Other Pacific Islander ☐ Black /African American ☐ American Indian/ Alaskan Native ☐ White ☐ More than one Race ☐ Unreported/Refuse to Report

Ethnicity ☐ Hispanic ☐ Non Hispanic

INSURANCE INFORMATION

☐ Commercial ☐ Medicaid ☐ Medicare ☐ Other Insurance ☐ No Insurance

PRIMARY Insurance Company:	Policy #	Group #:	Effective Date
Card Holder's Name:	Social Security Number	DOB	Employer & Phone Number
DENTAL Insurance:	Policy #	Group #:	Effective Date
Card Holder's Name:	Social Security Number	DOB	Employer & Phone Number

Primary Care Provider Name & Phone #

_____

Dentist Name & Phone #

_____

IN CASE OF EMERGENCY

We require the name, address, phone number and/or cell phone number of 2 contacts who are not family members.

_____ _____ _____

(Name of First contact) **(Address)** **(Phone and/or Cell #)**

_____ _____ _____

(Name of Second contact) **(Address)** **(Phone and/or Cell #)**

Signature of Parent/Guardian :_____ Date:_____

PLEASE SIGN THE BACK ------→

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) On Site 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
11) Dental examinations including: diagnosis, treatment, and sealants where available

It is important to note that the cost of services not provided on site at the SBHC, such as some laboratory tests, x-rays, specialty consultations and prescription drugs are the responsibility of the parent(s).

I hereby give consent for, _____ to receive health care services provided by the professional staff of the School-Based Health Center. I understand this consent expires when my child is no longer enrolled in the Jamestown Public Schools, or when a written statement is received.

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 **Primary Care Provider** 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 & Dentist.

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 The Resource Center - SBHC.

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 advice 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 & Dentist.**

NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received a copy of The Resource Center 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.

Parent/Guardian Signature: _____ Date: _____

Relationship: _____