Valley Health Care, Inc. School-Based Health Center Enrollment

I give consent to receive services at the Valley Health Care, Inc. School-Based Health Center located within my child's school.

All healthcare information is confidential. By signing the consent form you are giving the Valley Health Care, Inc., the school nurse, and your regular doctor (if applicable) permission to communicate and share medical information regarding your medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payers for billing purposes.

Confidentiality between the student, parents, school staff, and the health center is assured.

I am the legal guardian of the below named child. I understand that a new consent must be signed by the legal guardian if guardianship changes. I also understand that if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact.

☐ Yes, I would like for my child to have access to services at their School-Based Health Center.

☐ No, I do not wish for my child to have access to services at their School-Based Health Center.

Patient Name: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Signature of Patient (if over 18): _____

Date: _____

If you would like assistance in completing the consent packet, please feel free to contact us at any time.

CONTACT INFORMATION:
Valley Health Care Inc.
P.O. Box 247
Mill Creek, WV 26280
Phone: 304-335-2050
Fax: 304-335-2050
valleyhealthcarewv@gmail.com

Valley Health Care, Inc.
School-Based Health Center Enrollment

NAME (LAST, FIRST, MIDDLE):_____

MAILING ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

LOCATION WHERE YOU LIVE:_____ CITY:_____ STATE:_____ ZIP:_____

MALE_____ FEMALE_____

Ethnicity:

HISPANIC_____NON-HISPANIC_____

Race (Please Check All That Apply):

White___ Black___ Asian___ American Indian___ Native Hawaiian___ Pacific Islander_____ Other _____

DATE OF BIRTH:_____

GRADE IN SCHOOL FOR THE 2014-2015 SCHOOL YEAR:_____

SOCIAL SECURITY #:_____

HOME PHONE:_____ WORK PHONE:_____

MOBILE PHONE:_____ EMAIL ADDRESS: _____

NAME OF SCHOOL:_____

PARENT/GUARDIAN NAME(S): _____

PREFERRED PHARMACY: _____

SECOND EMERGENCY CONTACT (NAME):_____ PHONE:_____

RELATIONSHIP TO STUDENT: _____

FIRST INSURANCE COMPANY:_____ EMPLOYER:_____

POLICY IN THE NAME OF:_____ DATE OF BIRTH:_____

S.S. #:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS (IF DIFFERENT FROM RESPONSIBLE PARTY):_____

CITY:_____ STATE:_____ ZIP:_____

INSURED'S ID NUMBER:_____ GROUP NUMBER:_____

SECOND INSURANCE COMPANY:_____ EMPLOYER:_____

POLICY IN THE NAME OF:_____ DATE OF BIRTH:_____

S.S. #:_____ RELATIONSHIP TO PATIENT:_____

ADDRESS (IF DIFFERENT FROM RESPONSIBLE PARTY):_____

CITY:_____ STATE:_____ ZIP:_____

INSURED'S ID NUMBER:_____ GROUP NUMBER:_____

By signing this form I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school-based health staff if any of my child's demographic information changes.

Patient/Guardian Signature: _____ Date: _____

Questions about your child:

☐Yes ☐No Does your child have a Primary Care Doctor or Clinic? If Yes, please provide:
Provider Name: _____ Phone #: _____

☐Yes ☐No Has your child had a physical or full check up in the past year?

☐Yes ☐No Does your child have any MEDICATION allergies? _____

_____

☐Yes ☐No Does your child have allergies to anything else? (foods, dust mites, etc.)
If Yes, please List**:** _____

☐Yes ☐No Does your child take regular medications? (include vitamins and over-the-counter medications; please provide the name of the medication(s), the dosage, and the reason why the child is taking the medication)

_____

_____

_____

_____

☐Yes ☐No Is there any other medical information regarding the student that should be noted

_____

_____

_____

_____

☐Yes ☐No May we provide your child with over-the-counter medications as needed (e.g. Tylenol, Motrin, Benadryl)?

By signing this form I certify that the information provided is accurate to the best of my knowledge. I understand that providing incorrect information can be dangerous to the student/patient's health. I will contact school-based health staff if any of my child's medical history changes.

Patient Name: _____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Signature of Patient (if over 18): _____

Date: _____

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information. If you would like a copy of our HIPAA policies, please check the box below. This document is also available at www.vhcwv.org

☐ Yes, I would like to receive a copy of Valley Health Care, Inc.'s HIPAA policies.

Patient Name: _____

Patient DOB: _____

Patient Address: _____

_____

_____

Name of Parent/Guardian (Print): _____

Signature of Parent/Guardian: _____

Signature of Patient (if over 18): _____

Date: _____