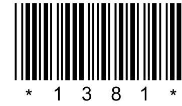
INITIAL SBHC ENROLLMENT

Bassett Healthcare Network
School-Based Health



Enrollment Form: Student Information

School: ☐ Cooperstown ☐ DASH ☐ Edmeston ☐ Laurens ☐ Middleburgh ☐ Milford
☐ Morris ☐ Schenevus ☐ Sherburne-Earlville ☐ Sidney ☐ South Kortright
☐ Stamford ☐ Unadilla Valley ☐ Worcester

Student Information:

Student's Legal Name: ______________________________

Home Phone (______)______________________________

Street Address: ______________________________

City: ____________________ State: ____ Zip__________

Mailing Address: (if different from physical address)

____

County: Chenango Delaware Otsego Schoharie (please circle)

Date of Birth:____/____/____ Sex: F___ M___ Grade:_____

Student Social Security Number:______________________________

Mother's Maiden Name:______________________________

Student's Doctor (Name):______________________________

Address & Phone #: ______________________________

Pharmacy (name/location):______________________________

Do you have a prescription plan? Yes ☐ No ☐

Student's Dentist (Name):______________________________

Do you have Dental Insurance? Yes ☐ No ☐

Parent Contact Information:

Parent/Guardian Name: ______________________________

Mailing Address and Phone (if different from student's or write SAME)

____

Daytime /Work/Cell Phone: ______________________________

____

Other Parent/Guardian Name:______________________________

Mailing Address and Phone (if different from student's):

____

Daytime /Work/Cell Phone:______________________________

____

Emergency Contact Information (other than parent):

Name:______________________________

Relationship to student:______________________________

Daytime Phone Number:______________________________

Address:______________________________

Name:______________________________

Relationship to student:______________________________

Daytime Phone Number:______________________________

Address:______________________________

☑ 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. I give my permission to the **School-Based Health Center** personnel to release medical records of all treatable visits to the health care provider listed above.

☐ 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.

Please read and sign the consent 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 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 mental health issues.

I WILL NOTIFY THE SCHOOL-BASED HEALTH CENTER IN WRITING IF I WISH TO REMOVE MY CHILD FROM THE HEALTH PROGRAM.

In order to provide optimal health care to your child, it is necessary for the School-Based Health Center staff and school nurse to regularly communicate and share medical and health related information. I hereby authorize the release of information from the School-Based Health Center to the school nurse and the school nurse to the School-Based Health Center. I understand that the information to be released is confidential and protected from re-disclosure. It will not be released except to the School-Based Health Center or school nurse without a completed authorization to do so.

X______________________________ Date: ______/______/_____

Parent/Guardian Signature

ENROLLMENT SBHC