Bassett Healthcare Network
School-Based Health

Please complete and return to the school-based health center in the provided envelope.

PLEASE DO NOT LEAVE BLANKS!

Student's **Legal** Name: _____ Date of Birth: ____/____/____ Sex: M / F Grade: _____

Parent/Guardian's Name: _____ Cell Phone: _____ Daytime Work #: _____

Student's Address: _____/_____
Physical address Mailing address if different

Home Phone #:_____

Emergency Contact Name: _____ Home/ Cell Phone: _____ Daytime Work #: _____

Address: _____Relationship to Student:_____
Physical address

Student's Current Insurance Information:

Please copy both sides of insurance card and send with this form. (If you bring the card to the SBHC we will make a copy)

Insurance Company: _____ Is this Child Health Plus ☐ Yes ☐ No

Phone # of Company: _____ Effective Date: _____

Insurance Co. Address: _____

Policy Holder ID #: _____ Group #: _____

If there is a two digit # next to student's name please provide after ID #

Name of Parent/Guardian who Provides the Policy _____ _____Date of Birth ___/___/___

Social Security # of Policy Holder _ _ _- _ _ -_ _ _ _

Policy Holder's Mailing Address: _____ Phone # _____

Employer of Policy Holder: _____ Policy Holder's Relationship to child: _____

Does your child have more than one Health Insurance Plan? ☐ Yes ☐ No (If yes please copy card or contact SBHC)

Medicaid ID# ☐☐ ☐☐☐☐☐☐☐☐ Access # _____ Seq# _____

Health Update

Please list any illnesses or injuries your child had during the previous year: _____

_____

Has your child had any vaccinations (immunizations) outside of the SBHC in the last year?

Please check ☐ **YES** ☐ **NO** **If Yes**, please list _____

Please list all your child's ALLERGIES: _____

_____

Do you have additional health concerns about your child? (including dental, emotional, and physical)

Please check ☐ **YES** ☐ **NO** **If Yes**, please explain: _____

_____

_____

Student's Doctor (Name): _____ **Address & Phone #:** _____

Pharmacy that you use: _____

☑ **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 be sure to read and sign the authorization below.

***Authorization to release information*:** I hereby authorize and direct the Mary Imogene Bassett Hospital and Bassett Medical Group to release to government agencies, insurance carriers, managed care companies or others who are financially liable for my medical care and their authorized agents all information needed to substantiate payment for this medical care and to permit representatives thereof to examine and request copies of records to this care and treatment. I further authorize the Mary Imogene Bassett Hospital, Little Falls Hospital, Cobleskill Regional Hospital, O'Connor Hospital, Tri Town Regional Hospital, and Bassett Medical Group to release billing information to any provider involved in my care. It may also be necessary, if your child is receiving services from a SBHC Mental Health clinician, for information to be discussed with other clinicians in the SBH mental health program as part of the case supervisory process. I understand that any shared information is confidential and protected from re-disclosure. 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 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 this information will not be released except to the SBHC or school nurse without a completed authorization to do so. It may also be necessary, if your child is receiving services from a SBHC Mental Health clinician, for information to be discussed with other clinicians in the SBH program. I understand that any shared information is confidential and protected from re-disclosure

***Assignment of Insurance Benefits*:** I hereby assign and transfer to The Mary Imogene Bassett Hospital, Little Falls Hospital, Cobleskill Regional Hospital, O'Connor Hospital, Tri Town Regional Hospital, and Bassett Medical Group sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover costs of the care and treatment rendered to myself or my dependent.

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

X_____ DATE_____
Signature of Legal Parent/Guardian

ENROLLMENT SBHC