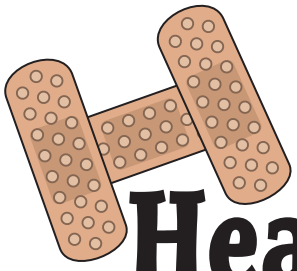

HealthHUB School Clinic

PO Box 542, South Royalton, VT 05068

Medical Enrollment Form

Parent/Guardian: Please complete this and the Pediatric Health History form.

Office use only:
Student ID # _____
Enrollment date _____
Info update _____

Authorization

I give my child permission to receive health care services at HealthHub. I authorize and consent to the prevention, diagnosis, treatment, and follow-up deemed necessary for my child's care. These services may include:

- Physical exams
- Written prescriptions
- Minor lab procedures
- Nutrition and weight counseling
- Identification of health risks and plans to reduce risks
- Mental health counseling
- Monitoring of chronic conditions
- Referrals for specialty services or services not offered
- Dental cleanings/screenings
- Immunizations.

HealthHub will provide any medical information to your insurance company as necessary to bill and substantiate the services your child received. You agree that HealthHub may bill your insurers and they may make their payments directly to the South Royalton Clinic. You will be billed for charges not covered by your insurance.

HealthHub will provide medical information to your primary care physician and referral health care providers as necessary to continue your child's medical care.

Patients have specific rights under state and federal law.

This permission will remain in effect until the child turns 20 or until parents rescind permission in writing.

Signature of Parent/Guardian_____

Date _____

Student's Name:
Last _____
First _____
Middle_____
☐ Male ☐ Female

Student's Race: *Please check one*
☐ White/Non-Hispanic ☐ Black/Non-Hispanic
☐ Hispanic ☐ Native American/Alaskan Native
☐ Asian/Pacific Islander ☐ Unknown
☐ Other (specify)_____

Student's Address and Phone:
Address_____
City _____
State _____ Zip _____
Home phone (_____)_____

Student's Date of birth _____

Student's Social Security_____

Student's Grade in School: _____

Mother/guardian's Name

_____
Home phone (_____)_____
Work phone (_____)_____

Father/guardian's Name

_____
Home phone (_____)_____
Work phone (_____)_____

Emergency Contact *if above unavailable*
Home phone (_____)_____
Work phone (_____)_____

With whom does the Student Live? *Check all that apply*
☐ Mother ☐ Stepmother ☐ Father
☐ Stepfather ☐ Guardian/Foster Parent
☐ Grandparent ☐ Sister/Brother
☐ Alone ☐ Own children
☐ Other _____

Student's Usual Source of Medical Care
Name of primary care provider and clinic

_____
Address_____
Phone (_____) _____
Date of last visit _____

Has the student seen a health care provider (e.g. physician or nurse practitioner) in the last year?
☐ Yes ☐ No. If yes, how many visits? _____
What were the main reasons for these visits?

_____

Has the student been seen in a hospital emergency room in the past year?
☐ Yes ☐ No. If yes, how many visits? _____
What were the main reasons for these visits?

_____

Medical Insurance *Check one*
☐ Medicaid/Dr. Dynasaur ☐ Private insurance
☐ Uninsured/self pay

Student's Insurance ID #s
Medicaid # _____
Personal ID # _____

Primary Insurance:
Company _____
Address_____
City _____State ____ Zip _____
Phone (_____) _____
Group name _____
Group # _____
Certificate # _____
Copay requirements _____

Secondary Insurance
Company _____
Address_____
City _____State ____ Zip _____
Phone (_____) _____
Group name _____
Group # _____
Certificate # _____
Copay requirements _____

Policy Guarantor (holder, subscriber)
Name_____
Address_____
City _____State ____ Zip _____
Phone (_____) _____
Date of birth_____
Effective date of enrollment _____
Relationship to student _____

Student's Usual Source of Dental Care
Name of dentist and clinic

_____
Address_____
City _____State ____ Zip _____
Phone (_____) _____
Date of last visit _____

Dental Insurance Company
Company _____
Address_____
City _____State ____ Zip _____
Phone (_____) _____
Policy # _____