BLUE RIDGE HEALTH

# BRH SCHOOL HEALTH CENTER STUDENT REGISTRATION & PERMISSION FORM

| **STUDENT INFORMATION** | | **ATTENDING SCHOOL:** | |
|---|---|---|---|
| Name (Last, First, Middle) | Birth Date | Gender ☐ Male ☐ Female | Grade/ Teacher |
| Ethnicity ☐ Hispanic ☐ Non-Hispanic | Race ☐ Native American ☐ White ☐ African American ☐ Asian | | Primary Language Spoken if Not English |
| Does the child have a regular doctor or other medical provider? ☐ Yes ☐ No Name of Provider or Clinic: | | Does the child have a regular dentist or dental clinic provider? ☐ Yes ☐ No Name of Dentist or Dental Clinic: If no, why does the child not have a dentist? | |

| **PARENT / COURT ORDERED LEGAL GUARDIAN INFORMATION** | | | |
|---|---|---|---|
| Name Date of Birth | | Relationship to Student | Does student live with you? ☐ Yes ☐ No |
| Street Address | | City, State, Zip | |
| Daytime Phone # May we test this number? | Work phone # and ext. | Other Phone (cell phone) # | Email Address |
| In Case of Emergency Contact/Relationship to Student | | Phone # | Other Phone (cell phone) # |

**STUDENT MEDICAL HISTORY**

Medication allergies: Reaction:

Other allergies: Reaction:

Daily medications: Reason for taking: How long have they taken this medication? **Preferred Pharmacy:**

Chronic Medical Conditions**: (Check all that apply)**

☐ Diabetes
☐ Sickle Cell Disease
☐ Heart Problems
☐ Autism/Autism Spectrum Disorder
☐ Other Issues:
☐ Attention Deficit Disorder (ADD/ADHD
☐ Kidney Disease
☐ Anemia
☐ Developmental Delay
☐ Asthma
☐ Depression
☐ Epilepsy

Has your child ever had chicken pox? ☐ Yes ☐ No **If yes, when?**

Has there been any change in your child's health during the past year? ☐ Yes ☐ No **If yes, explain.**

Has this child had a recent complete physical exam? ☐ Yes ☐ No **If yes, when?**

**If no, Would you like for your child to receive a complete physical in the School Health Center?** ☐ Yes ☐ No **If yes, please sign the statement below:**

I give permission for my child to have a complete physical exam at the School Health Center – signature: _____

I would like to be present for my child's exam**.** ☐ Yes ☐ No We will contact you before and after the appointment.

Has this child been seen in the emergency room in the past year? ☐ Yes ☐ No **If yes, when and why?**

Has this child ever had to stay in the hospital or have surgery? ☐ Yes ☐ No **If yes, when and why?**

Last dental exam? Any dental concerns? ☐ Yes ☐ No **If yes, explain.**

Has your child ever had any serious sports-related injuries? ☐ Yes ☐ No **If yes, give the age it occurred and describe injury.**

If your child receives a Sports Physical in the School Health Center; do you consent to releasing a copy of your child's completed sports physical forms to the school for sports participation purposes? ☐ Yes ☐ No

**Is there anything else you would like for the school health center to know about your child?**

**HOUSEHOLD INFORMATION**

Please name the people living in your household and their ages: **Example: Father (40), Stepmother (40), Sisters (6&8), Uncle (50), etc.**

Does anyone in the household smoke? ☐ Yes ☐ No

**FAMILY MEDICAL HISTORY**

Does anyone in this child's immediate family have any current health concerns? ***(Diabetes, High Blood Pressure, Asthma etc.)***

| Family Member | Age | Health Concern |
|---|---|---|
| | | |
| | | |

**TURN OVER PLEASE – BACK OF FORM MUST BE COMPLETED**

**NOTICE AND ACKNOWLEDGMENT OF PRIVACY PRACTICES**

Available upon request and on our website www.brchs.com you will find a **Notice of Privacy Practices** that details the way we keep your child's medical record confidential, and what rights you have to access that medical record. You will also find a form listing Student and Parent Rights & Responsibilities. We are required by Federal Law to provide you with this information and we ask that you **read the Notice of Privacy Practices and Rights & Responsibilities for both you and your child.** Please call (828) 692-4289 and speak to our BRH Privacy Officer if you have any questions. Thank you for your cooperation in our effort to comply with this law.

**INSURANCE INFORMATION*** Please send a copy of your insurance cards with this form or send the original **(we will make a copy and return the card to you)**

| | |
|---|---|
| Is the student covered by Medicaid or NC Health Choice?<br>☐Yes ☐ No ☐ Pending<br><br>Medicaid or NC Health Choice ID#: | Would you like information about Medicaid or NC Health Choice?<br>☐Yes ☐ No<br>Do you have another child in the home on Medicaid/NC Health Choice?<br>☐Yes ☐ No<br>What was this child's birthplace? State: Country: |

| | |
|---|---|
| Is the student covered by insurance?<br>☐Yes ☐No<br>**(If NO, please fill out the sliding fee information below to qualify for discounted charges)** | Would you like information about how you could get insurance through the Health Insurance Marketplace?<br>☐Yes ☐ No |

| | | | |
|---|---|---|---|
| Private Insurance | Name of Policyholder | Date of Birth | Relationship to student |
| Insurance Company Address **(to mail medical claims – check on the back of your insurance card)** | | | Insurance Phone # |
| ID Number (Policy #) | Group Number | | Social Security # **(for insurance purposes only)** |
| Date Coverage Began | | What is your deductible or co-pay? | |
| Policyholder's Employer | | Employer Address | |

Are you employed in Agriculture? ☐Yes ☐No

**If yes, what type of position do you hold?** ☐Grower ☐Migrant Farmworker (travel to seek work) ☐Year-round Farmworker ☐Seasonal Farmworker (live here; agriculture work during harvest season)

**APPLYING FOR THE BRH DISCOUNT SERVICES PROGRAM:** ☐ **Yes – I want more information on the BRH Discount Services Program**

If your child is uninsured at any time during the school year or you have a high insurance deductible plan, we would like to help by determining if you would qualify for discounted charges or our "sliding fee" which uses similar eligibility to the federal free and reduced lunch program. If you'd like to apply for this program, additional information must be completed to determine eligibility. Eligibility will be good for the entire school year.

1. I give consent for my child to receive any of the available services at a BRH School Health Center. BRH School Health Centers provide medical, dental, behavioral health, nutrition and social work services to enrolled students who have completed registration, including written consent and signature of the parent or legal guardian. Staff of the BRH School Health Center will inform parents of significant findings and treatment recommendations for minor children, for conditions other than those exempted by state law. For your convenience and at your request, some services may be provided by telehealth.
2. I authorize the release to my child's primary care provider, School Nurse and Student Support Services any medical information pertinent to my child's general health and care while they are at school. I authorize the release of information from my child's primary care provider, School Nurse, and Student Support Services to the BRH School Health Center for coordination of care.
3. I authorize the release of any medical information, including information on communicable diseases, dental, behavioral health and nutrition information necessary to process an insurance claim for payment of benefits to the BRH School Health Centers.
4. I authorize payment of insurance benefits for services rendered at the BRH School Health Centers, though Blue Ridge Community Health Services Inc.
5. I understand that Blue Ridge Community Health Services (BRH) operates the School Health Centers and I must contact BRH to make special payment arrangements if I am unable to pay the bill in full.
6. I understand that all my child's records will be strictly confidential, and maintained in compliance with state and federal laws, including HIPPA and FERPA and any paper records will be maintained onsite at the BRH SHC facility. Information is not shared with teachers, principals, or other students.
7. I confirm that all information given is complete and accurate.

Please sign the following declaration: **By signing this form, I authorize my child to receive all services available from the School Health Center. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled in school. I understand that I may also revoke my consent, in writing, at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid and NC Health Choice. I also understand that I am financially responsible for all charges and any co-pays or deductible amount not covered by my insurance. I further understand I am responsible for understanding my own insurance plan and whether services are covered or require pre-authorization. If services require pre-authorization, I understand this is my responsibility.**

**Parent/Guardian Signature:**_____

**Date:**_____

***NO STUDENT WILL BE DENIED HEALTH SERVICES BASED ON THEIR PARENT OR LEGAL GUARDIAN'S INABILITY TO PAY***

Please complete this form and save your changes. You will need to download the form to your computer and then email it to SBHCregistration@brchs.com. You can send copies of your child's insurance cards and other information to this email address. You may also download and print this form and send it back to your child's school.