HealthHUB School Clinic

Student Medical Services Enrollment Form

HealthHUB is a nonprofit organization with a mission to improve access to healthcare.

Please cross out and initial any statements below which you are unable or unwilling to sign.

- I have medical decision-making power for this student.
- I give my child permission to receive healthcare services by HealthHUB providers at my child's school. I authorize and consent to the prevention, diagnosis, treatment, and follow-up deemed necessary for my child's care. These services may include: sick and ell visits with associated physical exams, lab work and prescriptions, identification of health risks and plans to reduce risks, mental health counseling, monitoring of chronic conditions, referrals for specialty services or services not offered, and immunizations.
- I understand that HealthHUB has an arrangement with South Royalton Health Center (SRHC) to provide billing services for care provided to my child. I authorize HealthHUB via SRHC to provide any medical information to my insurance company as necessary to bill and substantiate the services my child receives. I agree that HealthHUB via SRHC may bill my insurer and my insurer may make payments directly to SRHC. I understand I will be billed for charges not covered by my child's insurance. My insurance may release my child's medication history to HealthHUB via SRHC.
- I agree HealthHUB can provide & share medical and demographic information with my child's primary care physician, school nurse, dentist and referral health care providers/specialists, and they can release information to HealthHUB as necessary to continue my child's medical care.
- HealthHUB may contact me via email and mobile phone.
- Patients have specific rights under state and federal law. I have reviewed the HIPPA/Privacy policy.

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

Student's Name: _____ Date of Birth: _____

Signature of Parent/Guardian _____ Date: _____

Please fill out the back side of this sheet.

Student's Information:
Address _____ City_____ State _____ Zip_____
Phone ( )_____ Student's Social Security _____(for insurance purposes)
Please circle: Male Female

Student's Race *(Please circle)*:
White/Non-Hispanic Black/Non-Hispanic Hispanic Asian/Pacific Islander
Native American/Alaskan Native Unknown Other_____ Prefer not to answer

Medical Insurance *(Please circle)*:
Medicaid Private Self Pay Insurance #:_____
Insurance Name/Address: _____
Who is Policy Holder:_____

Please attach a copy of the insurance card, front and back, or email it to kthorton@srhealthcenter.com.

Mother/Guardian's Information:
Name: _____ Phone: _____
Cell Phone: _____ Email: _____
Address if different than child's: _____

Father/Guardian's Information:
Name: _____ Phone: _____
Cell Phone: _____ Email: _____
Address if different than child's: _____

Student's Usual Source of Medical Care
Doctor/Primary Care Provider: _____
Dentist: _____
Eye Doctor: _____
Specialty care provider (if applicable): _____

Health History – please disregard if you have filled out the 3-page Health History form
Has the student seen a health care provider (e.g. physician or nurse practitioner) in the last year? *Please circle:*
Yes No
If yes, how many visits? _____ Reasons for these visits?_____

Has the student seen a dental provider in the last year? *Please circle*: Yes No
Reasons for these visits? _____

Is the student on any medication? Yes No Please list: _____

Is the student allergic to anything? Yes No Please list: _____

Does the student wear glasses or contacts? Yes No

Does the student have any chronic medical conditions or things they are treated for on a regular basis? (*for example, asthma, allergies, diabetes, mental health* _____

Has the student ever stayed overnight in the hospital or had any surgeries? Please describe.

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