FamilyCare Health Centers
Putnam County School-Based Health Services
P.O. Box 163 Eleanor WV 25070
(304) 380-7728/586-0001

ENROLLMENT AND CONSENT FORM

Patient Name: _____ SS #: _____
Address: _____ City: _____ State/Zip:_____
Phone: _____ Grade: _____ Birth date:_____ School:_____
Lives With: ____Mother ____Father ____ Both ____ Other: _____
Gender: *Female or Male* Race: *White, Black, Hispanic or Other:* _____

PARENT / GUARDIAN CONTACT INFORMATION

Father: _____ Phone (H) _____ (W)_____
(Cell) _____ Email: _____
Mother: _____ Phone (H) _____ (W)_____
(Cell) _____ Email: _____
Guardian: _____ Phone (H) _____ (W)_____
(Cell) _____ Email: _____
Alternate Contact: _____ Phone (H) _____ (W)_____
(Cell) _____ Email: _____

Patient's Insurance Coverage

☐ **Primary Health Insurance:**
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Address (if different from child)_____
Place of Employment _____
Name of Insurance Company _____
Insurance Address _____
Insurance Phone / Fax Number _____
Group & ID Number _____

☐ **Secondary Health Insurance**:
Name of Insured Parent / Guardian_____
Birth date of Card Holder_____ SSN of Card Holder _____
Name of Insurance Company _____
Insurance Address _____
Insurance Phone / Fax Number _____
Group & ID Number _____

Medicaid: Unicare Carelink Other: _____ (please circle one)
Medicaid ID#: _____ Member ID# (Carelink) _____
PCP/HMO Provider: _____ Provider Phone Number: _____

☐ **CHIP:** Name on Card: _____ Birth date of card holder: _____
ID or PIN # on card: _____ Group #: _____

☐ **No health insurance / Request application for sliding fee / CHIP / Medicaid**

Patient's Health Information

1. Please list any allergies, medications, chronic illnesses, or surgeries your child has/has had:

   _____

   _____
2. Doctor's name / phone number: _____
3. Would you like for us to provide your child's Well-Child Exam (physical) this year? Yes_____ No _____
4. When was your child's last dental exam? _____ Name of Dentist: _____
5. Immunizations: Please attach a copy of your child's immunization record.

NOTICE OF PRIVACY PRACTICES:

The Health Insurance Portability and Accountability Act (HIPPA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed and how a patient may obtain access to their personal health information. I may obtain a copy of the Privacy Practices by contacting the School-Based Health Center or FamilyCare's Eleanor Office (380-7728/586-0001). The Notice of Privacy Practice is also posted on our website at www.familycarewv.org. I acknowledge I have been provided this information.

_____ _____

Signature of Patient/ Parent or Guardian Date

Consent For Over The Counter Medication Administration:

No over the counter medications (OTC) will be given without consent on file. I grant permission for Putnam County School-Based Health to administer the following OTC medication to my child after evaluation and examination, as deemed necessary. Please circle the OTC medications you are permitting to be administered:

Ibuprofen Hydrocortisone Cream 1% Aceteminophen (Tylenol) Triple Antibiotic Cream/Ointment

CONSENT BY THE PARENT OR GUARDIAN TO TREAT THE STUDENT

I, the parent or guardian of _____, agree for my child to receive health care at the Putnam County School-Based Health Services Program sponsored by FamilyCare Health Centers. I understand that this consent form will be in effect until my child leaves the school or until I tell FamilyCare Health Center staff I do not want my child to receive care any longer.

By signing this form, I am giving FamilyCare Health Center, the school nurse and my child's regular doctor (if she or he has a regular doctor) permission to talk about and share medical information about my child. I understand that this information will always be kept confidential. Health information shared between the student, parents and FamilyCare Health Center will be kept private. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents or guardians. The staff will encourage every student to involve his or her parent or guardian in health care decisions.

No student will be denied access to health care services due to inability to pay. As in any health care center, there may be a charge depending on the service given. We will bill the patient's insurance or Medicaid, when available. FamilyCare Health Center may release information regarding treatment to third party payers for billing purposes. I understand that if guardianship changes, a new consent must be signed by the legal guardian. If I cannot be reached, medical information regarding the above child will be shared between the medical provider and the other contact.

_____ _____

Signature of Patient/ Parent or Guardian Date