

## MINOR PATIENT REGISTRATION

The Center for Rural Health Innovation

By completing this form, I consent in advance to my child having access to any or all-available services of MY Health-e-Schools as long as my child remains enrolled in Mitchell or Yancey County Schools. Services include: diagnosis and treatment of common illnesses and injuries; laboratory testing; preventive health screenings; health education; mental health services and referrals as needed.

## Students must have parental permission to be seen by MY Health-e-Schools.

Student's Name	(First, Middle, Last):				
DOB:	SSN: Age: Gende	er: M F Sch	ool:		
Mailing Address:			City:		Zip:
Primary Phone: _	Parent Email:				
Mother/Guardia	n:		Phone:		
Father/Guardian	:		Phone:		
Who does the ch	ild live with most of the time?				
In Case of Emerg	ency, please tell us a Local Friend or Relative (not living at san	ne address) w	hom we could c	ontact.	
Name:	Relationship:		Ph.:		
Person Responsil	ole for the Bill:				
Is the Patient cov	vered by insurance? YES or NO.				
Please fill in all o	f the following:				
Primary Insurance Name of Insurance Company:				CoPay Amount:	
	Ins. ID Number:		Group Num	nber:	
	Name of Subscriber:	D	OB:	SSN:	
	Patient's Relationship to Subscriber: SELF SPOUSE	CHILD O	THER:		
Secondary Ins.	Name of Insurance Company:			CoPay Amount:	
	Ins. ID Number:	Group Numl	Group Number:		
	Name of Subscriber:	D	OB:	SSN:	
	Patient's Relationship to Subscriber: SELF SPOUSE	CHILD O	THER:		
Primary Care Doo	ctor/Clinic:				
Pharmacy:			Town:		



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Child's Name:	DOB:
HIPAA/FERPA: All students have health issues that must b will share confidential information only in the following si	e handled in a confidential manner. MY Health-e-Schools staff tuations:
<ul> <li>when it is educationally relevant for a student when necessary to address a student's poto ensure the safety of the student, other other situations specified by law.</li> </ul>	tential health care needs,
For example, the MY Health-e-Schools staff may discuss the appropriate staff members who will administer the student student is at school.	he student's medication and other health care needs with the nt's medication and provide care to the student while the
are available on our website at www.crhi.org and at each	
I, the undersigned,	
	ave treatment through and by MY Health-e-Schools. I

- give permission and consent for my child to have treatment through and by MY Health-e-Schools. I understand the nature of this treatment, the way it is provided, and the details and limitations of this form and style of treatment.
- give permission for MY Health-e-Schools to receive information from the school about my child's health history.
- acknowledge that I have been offered a copy of the Notice of Privacy Practices (available on our website www.myhealtheschools.org or at the school nurse office).
- agree to release all records related to this treatment to the Primary Care Provider
- agree that all I will be responsible for all costs associated with said treatment and that I will provide
  any insurance information as requested. All costs and fees not covered by insurance will be my
  responsibility.
- As Parent/Guardian of the above student, I:
  - authorize the release of any information necessary to process insurance claims for payment of benefits to MY Health-e-Schools.
  - authorize payment of benefits to MY Health-e-Schools for services rendered.
  - have provided details of all insurance policies that cover my child.

The information above and on the proceeding page is true and complete to the best of my knowledge.

Parent/Guardian name PRINTED:						
Parent/Guardian SIGNATURE:						
Date:						



## MY Health-e-Schools Student Health Questionnaire

Student's Last Name		First	Middle	
Student Date of Bir	th Gender	School		
	have any of the follow ther than medications (suc			i:
o Asthma - D	ate of last asthma attack _			
	Date of last seizure			
<ul><li>Vision Prob</li></ul>				
<ul> <li>Hearing Pro</li> </ul>	oblems			
<ul> <li>Sickle Cell A</li> </ul>				
<ul> <li>Heart Probl</li> </ul>	ems - <i>Please list</i>			
<ul> <li>Bleeding Di</li> </ul>	sorders			
<ul> <li>Orthopedic</li> </ul>	(bone or joint) Problems			
<ul> <li>Anxiety/Dep</li> </ul>				
	and/or Hospitalizations - L	Dates (details below)		
<ul> <li>Diseases in</li> </ul>	J			
o Other - <i>Plea</i>	ase explain			
=	any medications?			
o No				
o Yes - Pleas	se list			
o No	ergic to any medication			
• •	, I am stating the following information that I have pro		p-to-date.	
• <i>I wil</i>	l update MY Health-e-Scho	ools with any changes a	s soon as possible.	
If you would like to e-Schools at (828)	speak with our medical pri 467-8815.	ovider about any of your	child's health, please	contact MY Health
Parent/Guardian S	ignature		 Date	005.MYHS