CHBS
COMMUNITY HEALTH
& BEHAVIORAL SERVICES
A PROGRAM OF UPSTATE CEREBRAL PALSY

SCHOOL BASED HEALTH CENTER AT
JAMES H. DONOVAN MIDDLE SCHOOL
1701 Noyes Street – Utica, NY 13502
(315) 368-6593 Fax (315) 223-4464

ENROLLMENT FORM

Student Name: ______________________ **Date of Birth:** ____/____/______ **Sex: F**___ **M**___

Phone: (____)______________ **Cell:** (___)______________ **Social Security Number**______________

Address: ______________________ **City:** ____________ **State:** _____ **Zip:** ______

Mother's Name: ______________________ **Father's Name:** ______________________

Mother's Date of Birth: _________ **SS#**__________ **Father's Date of Birth:** ________ **SS#**__________

Employer's Name: ______________________ **Employer's Name:** ______________________

Employer's Address: ______________________ **Employer's Address:** ______________________

Mother's Address: ______________________ **Father's Address:** ______________________

Work Telephone: ______________ **Ext.** _____ **Work Telephone:** ______________ **Ext.**_____

Legal Guardian: **Dad** ☐ **Mom** ☐ **Shared** ☐ **Other (Explain):** ______________________

Emergency Contact: **Name:** ______________ **Relationship to student:** ________ **phone #** ________

Please check only one box below which best fits your needs

☐ My child regularly goes to another doctor or clinic for health care. I would like the **School Based Health Center** to work with my child's doctor/clinic to keep my child healthy. **Doctor's Name and Address**: ______________________

☐ My child does not have a regular doctor or clinic. I would like the **School Based Health Center** to provide health care as necessary to keep my child healthy.

Please read and sign the consent below.

I give consent for my child to receive health care services provided by the staff at the School Based Health Center. I understand that I may or may not be present for my child's medical appointment. The staff of the School-Based Health Center considers parental involvement very important. In order to provide optimal health care to your child, it may be necessary for the School Based Health Center staff and school nurse to regularly communicate and share medical and health related information.

______________________________ ______________
Signature of Parent/Guardian Date

HEALTH INSURANCE INFORMATION

Is Student covered by health insurance? Yes ☐ **No** ☐ **Is Student covered by Medicaid? Yes** ☐ **No** ☐

If Yes, Student's Medicaid #: ___ ___ ___ ___ ___ ___ ___ ___ **Sequence #:** ___ ___

PRIMARY INSURANCE AND ADDRESS: ______________________ **Policy #** __________

Group # ________ **Effective Date:** ________ **Employer of Insured:** ______________ **D.O.B. of Insured:** ______

Name of Insured Person: ______________________ **Relationship of Patient to Insured:** __________

SECONDARY INSURANCE AND ADDRESS: ______________________ **Policy #** __________

Group # ________ **Effective Date:** ________ **Employer of Insured:** ______________ **D.O.B. of Insured:** ______

Name of Insured Person: ______________________ **Relationship of Patient to Insured:** __________

MY INSURANCE COVERS IMMUNIZATIONS: (circle one): YES NO UNKNOWN

BILLING CONSENT: INSURANCE AUTHORIZATION AND ASSIGNMENT

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits to be paid directly to Upstate Cerebral Palsy Agency. I also authorize Upstate Cerebral Palsy to release any information requested by insurance company (ies) including medical, surgical, drug, alcohol, and/or psychiatric information. Release of HIV/AIDS information may require further authorization.

______________________________ ______________
Signature of Parent/Guardian Date