VNA Health Care

# Registration Form

**Romeoville School Based Health Center**

in Collaboration with **Valley View School District 365U**

**School ID #**_____ **Date** _____

**Student/Patient Information** ☐ Student at _____ Grade_____

Name _____Birthdate _____ ☐ Male ☐ Female

Race ☐ Asian/Pacific Islander ☐ Black/African American ☐ White ☐ Native American/Aleutian
☐ More than one race ☐ Other _____ ☐ Decline to Report
Ethnicity ☐ Hispanic ☐ Non-Hispanic ☐ Decline to Report

Address_____
Street City State Zip

**Parent/Guardian** _____ Phone # Home ( ) _____
(Name)

Work Phone # ( ) _____ Employer _____

Preferred Language ☐ English ☐ Spanish ☐ Other _____
Marital Status ☐ Single ☐ Married ☐ Divorced

**Emergency Contact** _____ _____
(Name) (Relationship to Student)

Phone # Home ( ) _____ Work ( ) _____

**Doctor or Clinic** _____ Phone # ( ) _____

**Medical Coverage:**
☐ Medicaid/Blue Cross Community ☐ Medicaid/Harmony ☐ Medicaid/Meridian
☐Medicaid/Illinois Health Connect
☐ Medicaid/Other _____ ID# _____
☐ Private Insurance: (circle one) HMO or PPO Date of Birth (Parent/Guardian)_____
Name of Insured (i.e. parent/guardian) _____
Social Security Number / ID of Insured_____
Employer of Insured _____
Policy Number _____ Group Number _____
Address and Phone Number of Insurance Company _____
_____

☐ No medical coverage Weekly income for the household $_____
Household Size (number of people supported by income) _____

**Consent:** I hereby give consent for the services offered at VNA Health Care and/or the VNA Mobile Health Clinic. I have been informed and understand the scope of services to be provided. I further understand that confidentiality between the student/patient and Health Center professionals will be ensured in specific areas designated by law and will not be discussed with the parent/guardian unless the student agrees. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care service. I authorize exchange of information between VNA Health Care and School District 365U strictly in regards to school and sports physicals and immunization records only. I authorize VNA Health Care to release information to third party payers for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

_____ _____ _____ _____
(Parent or Guardian for students under 18) Date (Students over 12 or Patient) Date