TheHealthCenter
PO Box 1075, Walla Walla WA 99362 | 509-529-5661

STUDENT REGISTRATION Today's Date:_____

Student Name:_____
LAST FIRST M.I.

Address:_____
STREET CITY STATE ZIP

Phone (H) _____ Phone (C)_____ OK to text? □ Yes □ No

Student Birthdate: _____ Age:_____ Grade Level:_____ Sex: □ **Male** □ **Female**

Race – Please check one

□ Asian/Pac. Islander □ Hispanic □ Ntv. American / Aleutian / Ntv. Alaskan
□ Black □ White/Not Hispanic □ Other

Insurance Information

Does your child have insurance? □ Yes □ No □ Unsure

Name of Insured Person: _____ Insured Person's DOB: _____

Insurance Company: _____ Insurance ID#:_____

Group Number: _____

Insurance Company Address/Phone #: _____

Student Health Information (add sheets as needed)

Does your child have a Primary Care Physician? □ No □ Yes (name)_____

If not, may we refer you to one? □ Yes □ No

Has your child seen your Primary Care Physician in the last year? □ Yes □ No

When possible, follow-up services are referred back to the student's primary care physician.

Current Medications: _____

Allergies (if any): _____

Chronic illnesses (past/present): _____

Other important health history: _____

What pharmacy do you use?: _____

Vaccinations

I permit this student to be updated for all Washington State recommended immunizations for birth to 12 years of age, as appropriate. These include: DTaP, Hepatitis A, Hepatitis B, HPV, Influenza, Meningococcal, MMR, TDap, and Varicella.

□ Yes □ No □ Please notify me before immunizing

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Parent/Guardian Information:

(Parent 1) Name: _____ Phone #s: (H) _____ (W) _____ (C) _____

(Parent 2) Name: _____ Phone #s: (H) _____ (W) _____ (C) _____

Emergency Contact:

Name: _____ Phone: _____ Relationship: _____

CHARGES: Insurance may be billed for immunization(s) & services provided by The Health Center. No student will be denied service because of inability to pay. Any services provided outside of The Health Center, such as pharmacy, radiology, or laboratory, are the responsibility of the parent or guardian.

OUR PRIVACY OBLIGATIONS: The Health Center is required by law to maintain the privacy of your health information. A copy of the Notice of Privacy Practices and Student Rights & Responsibilities are available upon request by contacting The Health Center.

Parental Consent:

I have read and understand the above information and authorize _____ to receive physical and behavioral health services including a wellness physical provided by a Licensed Independent Practitioner from The Health Center. Generic over-the-counter medications, such as Tums, Tylenol, and Benadryl are available at The Health Center. My signature allows licensed medical staff the ability to distribute these medications as needed, without calling for authorization first. I understand The Health Center always supports and encourages parental involvement in decisions about my student's healthcare. I authorize The Health Center and my student's school to share information related to medical or behavioral health care. I recognize these records once received by The Health Center may not be protected by the Family Education Rights and Privacy Act (FERPA) but may be protected by the Health Insurance Portability and Accountability Act (HIPAA) and other federal and state laws. I also authorize the release of any medical, behavioral and protected health information necessary to process insurance claims and authorize payment of medical benefits for services. This consent form will remain in effect for 12 months, until a written decision to revoke consent is given to The Health Center; or if student withdraws from school.

To give permission for your student to use The Health Center SIGN HERE:

Parent/Legal Guardian Signature: _____ Date: _____