The Hornet Health Center

Student Enrollment Form

Today's Date: ___/___/___ Primary Care Physician: _______________________

Patient Name: ____
First Middle Last

Home Address: ____
Street City State Zip

Preferred Phone: __________________ Alternate Phone: __________________

Birth Date: ___/___/_____ Age: ____ Male / Female SSN:_______________

Parent/Guardian Name: ____

Mailing Address (if different from physical address):

____
Street City State Zip

Preferred Pharmacy:______________________________ Phone: _____________

Please list whom we may notify in the event of an emergency:

Contact: _________________________________ Relationship: _______________

Telephone:___________________

Contact: _________________________________ Relationship: _______________

Telephone:___________________

The Hornet Health Center

Insurance Information

Primary Medical Insurance: ____

Group Number: ____________ Insurance ID Number: ______________________

Patient's relationship to insured: Self Child Other: ___________________

Secondary Medical Insurance:____

Group Number: ____________ Insurance ID Number: _____________________

Primary Care Physician: ____

***Please provide a copy of your insurance card as well as a photo id.**

_______________Complete this section if patient is a minor_______________

Responsible Party: _______________________Relation to Patient:__________

Birth Date: ___/___/_____ Male / Female SSN: __________________

Age: ______ Marital Status: Single Married Widowed Divorced

Spouse's Name:______________________________

Mailing Address (if different from patient):

____

Street City State Zip

Employer: ____

Work Phone: ____________________

All operations of the Bryant SBHC and their providers will be in full compliance with the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act (HIPAA).

I understand my insurance will be billed for services provided by the SBHC and I authorize the provider to use my signature for all on insurance submissions.

I understand all information regarding services provided in the SBHC will be shared with my primary care physician (as applicable).

I understand that Bryant SBHC providers are located on the Bryant Elementary Campus, and it may be necessary for a student to be transported to the SBHC from another campus. I give my permission for my child to be transported via a school bus by an employee of the Bryant School District to/from the SBHC as needed.

I authorize an approved representative from the Bryant School District to pick up prescriptions medications from the pharmacy, or approve the pharmacy to deliver medications, for my child if the need arises. A parent must pick up the medication(s) from the health center directly. No medication will be sent home with a student.

There will be an opportunity to read the HIPAA Privacy Practices for Protected Health Information.

Patient Name ______________________________________

Responsible Party **Printed** Name ____

Responsible Party **Signature** ____

Date: ____/ ____/______

*Every attempt will be made to notify a parent/guardian by phone before the student receives any services at the SBHC.