Roanoke Chowan Community Health Center Student Registration & Consent Form

Please know that your child can use the School-Based Health Center and see your other doctors. Signing this consent does not change your insurance, does not change your private doctor, and does not affect the number of times your child can see their private doctor.

Student Information			
Name (Last, First, Middle Initial)		Birth Date	Gender ☐ Male ☐ Female ☐
Grade	Ethnicity ☐ Hispanic ☐ Non-Hispanic	Social Security Number (optional field, for insurance purposes only)	
Race ☐ African American/Black ☐ American Indian ☐ Alaskan Native ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ White ☐ Other		Address City State Zip	
Primary Language Spoken	Student Cell Phone	Student Email Address	
Parent Information			
Name (Last, First, Middle Initial)		Relationship to student:	Phone Number:
Name (Last, First, Middle Initial)		Relationship to student:	Phone Number:
Emergency Contact In the event the listed parent cannot be reached, we will contact the person below			
Name (Last, First, Middle Initial)		Relationship to student:	Phone Number:
Student Medical History			
Does the child have a primary care provider? ☐ Yes ☐ No Name of Clinic: Date of last exam: If not, would you like to establish care with RCCHC? ☐ Yes ☐ No		Does the child have a dental provider? ☐ Yes ☐ No Name of Clinic: Date of last exam: If not, would you like to establish care with RCCHC? ☐ Yes ☐ No	
Allergies:		List current medications:	
List any medical conditions (asthma, migraines, diabetes etc).			
Pharmacy Information			
Name:		Phone Number:	

insurance cards and other information to this email address. You may also download and print

Student's Insurance Information Please provide a copy of the insurance card if able. The School-Based Health Center provides care to students whether or not they have insurance. If the student has Medicaid or other insurance, it is important to inform the School-Based Health Center in order to bill for the services.	
☐ My child does not have health insurance ☐ My child has Medicaid. ID # ☐ My child has other insurance Health Plan Name: Member ID/Policy Number:	Would you like information about enrolling in Medicaid? ☐ Yes ☐ No RCCHC offers a Sliding Fee Scale Discount program. Would you like more information on this program? ☐ Yes ☐ No
Notice and Acknowledgment of Privacy Practices	
Available upon request, posted in the clinic, and on our website www.rcchc.org you will find a Notice of Privacy Practices that details the way we keep your child's medical record confidential, and what rights you have to access that medical record. We are required by Federal Law to provide you with this information and we ask that you read the Notice of Privacy Practices and Rights & Responsibilities for both you and your child. Please call (252)332-3548 if you have any questions. Thank you for your cooperation in our effort to comply with this law.	

1. I give consent for my child to receive any of the available services at the RCCHC School Based Health Center(s). RCCHC School Based Health Centers provide medical, dental, behavioral health, nutrition, and social work services to enrolled students who have completed registration, including written consent and signature of the parent or legal guardian. Staff of the SBHC will inform parents of significant findings and treatment recommendations for minor children, for conditions other than those exempted by state law. These services may be provided in person or via telehealth.
2. I authorize the release to my child's primary care provider, School Nurse and Student Support Services any medical information pertinent to my child's general health and care while they are at school. I authorize the release of information from my child's primary care provider, School Nurse, and Student Support Services to the RCCHC School Based Health Center for coordination of care.
3. I authorize the release of any medical information, including information on communicable diseases, dental, behavioral health and nutrition information necessary to process an insurance claim for payment of benefits to the RCCHC School Based Health Centers.
4. I understand that all my child's records will be strictly confidential, and maintained in compliance with state and federal laws, including HIPPA and FERPA and any paper records will be maintained onsite at the RCCHC SBHC facility. Information is not shared with teachers, principals, or other students.
5. I confirm that all information given is complete and accurate.
   No student will be denied health services based on their parent or legal guardian's inability to pay.

Please sign the following declaration: By signing this form, I authorize my child to receive all services available from the School Based Health Center. I understand that this consent is voluntary and is valid for the entire time that my child is enrolled in school. I understand that I may also revoke my consent, in writing, at any time. I understand that it is my responsibility to provide up-to-date information on the insurance coverage I carry on my child, including Medicaid and NC Health Choice.

Parent/Guardian Signature:

Date:

Please complete this form and save your changes. You will need to download the form to your computer and then email it to sbhcregistration@rcchc.org. You can send copies of your child's insurance cards and other information to this email address. You may also download and print this form and send it back to your child's school or the SBHC.

RCCHC
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