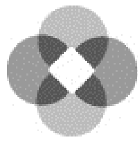
VNA Health Care

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: _______________________________ Home Phone #: ( ) ____________________
Name

Work Phone #: ( ) __________________ Employer: ______________________________________

Preferred Language: ☐ English ☐ Spanish ☐ Other: _______________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced

Emergency Contact: ____
Name Relationship to Student

Home Phone #: ( ) _____________________ Work Phone #: ( ) __________________________

Doctor or Clinic: ______________________________ Phone #: ( ) ___________________________

Medical Coverage:

☐ Medicaid/Blue Cross Community ☐ Medicaid/Meridian ☐ Medicaid/IlliniCare

☐ 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: ______________________________________

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☐ No medical coverage Weekly income for the household: $__________________________________

Household Size (number of people supported by income): _________________________________

☐ Yes, my child may participate in VNA Health Care's After School Snack Program. Snacks may contain one or more allergens including wheat, soy, eggs, dairy or nuts.

Consent: I hereby give consent for the services offered at the VNA Health Center located at 160 N. Independence Blvd, Romeoville 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 school and sports physicals and immunization information between VNA Health Care and Valley View School District 365U. I acknowledge that other information, as permitted by law, may be exchanged between VNA Health Care and Valley View School District 365U. 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. This authorization is valid until the individual turns 18 or until revoked by mailing a letter to: VNA Health Care, Attn: Medical Records, 400 N. Highland Ave., Aurora, IL 60506.

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