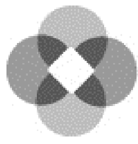

VNA Health Care

Registration Form

VNA Health Center & VNA Mobile Health Clinic

in Collaboration with **East Aurora School District 131**

School ID #:____________________ **Date: ______________________**

Student/Patient Information: Student at: ______________________________ Grade:____________

Name: _________________________________Birthdate: ______________ ☐ Male ☐ Female ☐ Transgender ☐ Other

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 Plan: ____ 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 the VNA Health Center located at East Aurora High School 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 agree to allow VNA Health Care to release personal, medical and billing information to East Aurora School District 131. 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. This authorization is valid until the individual turns 18 or until revoked in writing 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