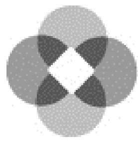 VNA Health Care

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 ☐ 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): __________________________________

☐ 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 agree to allow VNA Health Care to release personal, medical and billing information to Valley View School District 365U. 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