CHS **Community Health Services**
Your Partners for Better Health

NAPOLEON SCHOOL REGISTRATION

STUDENT NAME: _____ DOB: _____

ADDRESS: _____

SEX: ☐ MALE ☐ FEMALE SOCIAL SECURITY # _____-_____-_____

PARENT(S)/GUARDIAN(S) NAME(S): _____

PRIMARY PHONE # _____ CELL PHONE # _____

EMAIL ADDRESS: _____

PREFERRED PHARMACY INCLUDING CITY: _____

MEDICAL INSURANCE

MEDICAID MMIS # _____

OTHER MEDICAL COVERAGE:

INSURANCE NAME: _____

SUBSCRIBER NAME: _____ SUBCRIBER DOB: _____

SUBCRIBER SOCIAL SECURITY #: _____-_____-_____

RELATIONSHIP TO PATIENT: _____ ID #: _____ GROUP #: _____

I hereby authorize the release of any medical information necessary for the processing of third party payers. I also authorize insurance benefits to be paid directly to Community Health Services. I understand that if my insurance does not pay, I am responsible for payment for service provided.

CONSENT

I hereby voluntarily consent to care, treatment and services provided by Community Health Services medical providers and their designees. I acknowledge that services will be provided at the school clinic during school hours and treatment will be provided in the absence of the parent/guardian. If deemed necessary by the provider, students may be referred to their primary care physician, Community Health Services or to specialists for further evaluation. It is the responsibility of the parent/guardian to be compliant with any recommended further evaluation. In giving consent for treatment, I understand that I retain the right to refuse any of the care, treatment or services recommended or deemed medically necessary by the treating provider.

This authorization will expire at the end of the school year in which it was signed.

SIGNATURE (PARENT/GUARDIAN): _____ DATE: _____