BALTIMORE CITY HEALTH DEPARTMENT
SCHOOL-BASED HEALTH CENTER REGISTRATION
School Health-Improving Tomorrow for Today's Kids

Do Not write in this space
Registration ID: __/__/__/__/__/__/__/__/__/__/ Initials_____

Last Name: _____ First Name: _____ MI:___
Race/Ethnicity: _____ Birthdate: ____/_____/_____
Sex: M/F Social Security Number: _____/____/_____ Grade: _____
Address: _____Zip Code: _____Phone: _____
Parent/Guardian: _____ Daytime Phone: _____Home/Work
Emergency Contact: _____Relationship to Child: _____

I grant permission for my child _____ to enroll in the school-based health center in his/her school. I consent to his/her receiving health services that can include physical examinations, treatment for acute and chronic health problems, health education, mental health counseling, and limited diagnostic tests. I give consent for the submissions of all claims, if applicable, to my private insurer, managed care organization (MCO) or HMO and authorize direct payment to the Baltimore City Health Department for any benefits due.

- I understand that if my child is registered with a Managed Care Organization (MCO) through Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school health center. A summary of the visit will be sent to the primary care provider/MCO.
- I understand that school personnel will not have access to any of my child's medical records and the results of all examinations and counseling are strictly confidential.
- I understand that Maryland law allows a minor to give consent for treatment or advice about drug abuse, alcoholism, sexually transmitted diseases, pregnancy, and treatment or advice about birth control. A minor 16 years or older may consent to mental health services. Under these circumstances, only information necessary for billing purposes or as required by Maryland law will be released outside the clinic.

✶*Signature of Parent/Legal Guardian*_____
*Today's Date*_____

PROVIDER, INCOME AND INSURANCE INFORMATION

Name of Student's Primary Provider (Doctor or Clinic) _____
Address_____ Phone # (410)_____

✶ *IF YOUR CHILD HAS MEDICAL ASSISTANCE: please complete the following*

CHILD'S Medical Assistance # _____

Name of Managed Care Organization: _____

If you have not selected a MCO, write none

✶ *IF YOUR CHILD HAS PRIVATE INSURANCE: please complete the following*

Name of Policyholder _____ Relationship to child_____
Policy # or Social Security #(Please include suffixes or prefixes)_____
Place of Employment _____Phone: _____
Employment Address _____City/State/Zip _____
Name of Insurance Company _____

✶A CHILD WILL NEVER BE DENIED SERVICES BECAUSE OF INABILITY TO PAY✶

Income: _____ Weekly/Biweekly/Monthly/Annual (Circle One)

Number of Dependents_____

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