CASCADE MEDICAL
PARTNERS IN YOUR HEALTH

Today's Date: _____

STUDENT REGISTRATION

Student Name: _____
Last First M.I.

Address: _____
STREET CITY STATE ZIP

Phone (H) _____ **Phone (C)** _____ **Other** _____

Student Birthdate: _____ **Age:** _____ **Grade Level:** _____

Insurance Information

Does your child have insurance? ___ Yes ___ No ___Unsure

Name of Insured Person: _____ Insured Person's DOB: _____

Insurance Company: _____ Insurance ID#: _____

Group Number: _____

Insurance Company Address / Phone #: _____

** If possible, please give your insurance card to the provider or assistant so they can make a copy **

Student Health Information (add sheets as needed)

Does your child have a Primary Care Provider? ___ No ___ Yes (Name) _____

Has your child seen their Primary Care Provider in the last 12 months? ___ No ___ Yes

Chronic illnesses (past/present): _____

Other important health history: _____

_____

Current medications: _____

Allergies (if any): _____

How long have you lived in your current location? _____

Is housing currently a concern for you? _____

Which pharmacy do you use? _____

To your knowledge, is your child up to date on all immunizations? _____ Yes ___ No

Emergency Contact

Name (#1): _____ Phone: _____ Relationship: _____

Name (#2): _____ Phone: _____ Relationship: _____

CHARGES: Insurance will be billed for services provided by the Cascade Medical provider when services are provided at schools in the Cascade School District. No student will be denied service because of the inability to pay. Any services provided outside of this visit such as pharmacy, radiology, or laboratory, are the responsibility of the parent or guardian.

OUR PRIVACY PRACTICES: Cascade Medical is required by law to maintain the privacy of your health information. A copy of the Notice of Privacy Practices and Student Rights & Responsibilities is available upon request by contacting Cascade Medical or discussing it with the provider. By law, we are able to share any pertinent health information with the school nurses. Health information will not be shared with any other school district employees without the written consent of either the student or parent (depending on student age as according to law).

Parent Consent

I have read and understand the above information and authorize _____ (student name) to receive physical and behavioral health services including a wellness physical provided by a Licensed Independent Practitioner from Cascade Medical. I understand Cascade Medical always supports and encourages parental involvement in decisions about my student's healthcare. I authorize the release of any medical, behavioral and protected health information necessary to process insurance claims and authorize payment of medical benefits for services. This consent form will remain in effect until the end of the current school year, until a written decision to revoke consent is given to Cascade Medical, or if a student withdraws from school.

To give permission for your student to use Cascade Medical provider services at the schools of the Cascade School District please sign here:

Parent/Legal Guardian Signature: _____ Date: _____