VINE SCHOOL HEALTH CENTER

☐ New Patient ☐ Established Patient ☐ Foster Care/DCS

REGISTRATION FORM FOR SERVICE/TREATMENT ***(Please check all that apply)***

Child's Information		
Child's Name:	**Child's Birth Date:**	**Child's Gender:** **Male** **Female** **Other** **Child's Race:**
Child's Social Security Number:	**Current Pharmacy/Address:**	
Child's Address (street, city, and zip code):	**Child's Current School and Grade**	

Legal Guardian's Information: This section must be completed by a biological parent or appointed by the court to be guardian.		
Parent (1) Name:	Parent (2) Name:	Child in DCS/Foster Care/Kinship? Yes No ○ **Custody Documents Provided to the Center**
Parent (1) Birth Date:	Parent (2) Birth Date:	Foster Parent Name:
Parent (1) cell phone #:	Parent (2) cell phone #:	Foster parent cell phone #:
Parent (1) Email:	Parent (2) Email:	Case Worker's Name & cell phone #:

Insurance Information: All Services require a form of payment	
Insurance Provider: Self-pay None	Policy Number/ Group Number:
Guarantor's Name (If insurance is TNcare, leave blank):	Parent/Guardian's Employer & Phone:

Additional Information about your child:		
Child's Current Medication (Prescribed or over the Counter):		
Does the child have any allergies? No Yes To What?	Is the child on free or reduced lunch program at school? **No** **Yes**	Does the child have a Primary Care Provider? **No** **Yes** **Who?**
Have any mental health problems? **No** **Yes** **Diagnosis:**	Have any current/past health problems? **No** **Yes** **Diagnosis:**	Have an IEP or Special Education services? **No** **Yes** **Disability:**

Authorized Individuals to participate in your child's care at Vine School Health Center:

I consent for Vine School Health Center to disclose personal/physical/mental health information of my child consisting of: appointment information, diagnosis, and/or medical/mental health/medication information/instructions to *(List names of designated persons and contact numbers)*:

Name of Person/Emergency Contact:	Phone #	Relationship to the Child:
Name of Person:	Phone #	Relationship to the Child:

Please initial the following statements:		
Initial		I have been provided a copy of the Health Center's Notice of Privacy Practices Agreement to review or can request a copy.
Initial		I give East Tennessee Child's Hospital permission to release health information to the Vine School Health Center regarding my child's evaluation and treatment.
Initial		I give Vine School Health Center permission to release information to Knox County School System regarding my child's care.
Initial		I understand, Vine School Health Center will bill insurances for services. If applicable, services qualify for a sliding scale fee/self-pay.

In order for this child to have services at Vine School Health Center, please sign below:

The Vine School Health Center is a collaborative effort between Knox County Schools and the University of Tennessee, College of Nursing and is located in the Vine Middle Magnet School and with satellite clinics in other schools. I understand that these services, performed when requested by parents or after parents have been contacted by clinic staff, care will be provided by nurses, nurse practitioners, social workers, social work interns, student nurse practitioners, and student nurses, and physicians, and include but are not limited to: well child exams, immunizations, health education, acute illness care, general first aid, mental health counseling, case management, and sport physicals. By signing this form, I am giving my permission for this child to receive services from the Vine School Health Center.

Parent/Guardian's Signature: _____ **Date:** _____