Adolescent Medicine & Student Health Services
Registration & Permission Form

Patient Information

Name _____ Date of Birth _____

Address _____

Home Phone _____ Cell Phone _____ Email _____

Sex _____ Gender Identity _____ Preferred Pronouns _____ Race _____

Preferred Language _____ Interpreter Needed ☐ Yes ☐ No Religion _____

Education ☐ Public ☐ Private ☐ Homeschooled Where? _____

Guarantor Information (Parent / Legal Guardian)

Please provide any custody paperwork and/or placement agreements if applicable

1st Parent/Guardian Name _____ Date of Birth _____

Address _____ City/State _____ ZIP _____

Home Phone _____ Cell Phone _____ Email _____

2nd Parent/Guardian Name _____ Date of Birth _____

Address _____ City/State _____ ZIP _____

Home Phone _____ Cell Phone _____ Email _____

Marital Status of Parents ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If separated, what is the patient's custody status? _____

Coverage Information

Insurance _____ Policy Holder's Name _____

Subscriber ID _____ Group # _____ Effective Date _____

Emergency Contact(s) *(May bring patient to appointments with signed consent forms)*

#1 Name _____ Phone _____ Relation to Patient _____

#2 Name _____ Phone _____ Relation to Patient _____

10/21 618463

CHART-5033

PATIENT IDENTIFICATION

Adolescent Medicine & Student Health Services
Registration & Permission Form

Patient's Name: _____ _____

Last *First* *MI* *Date of Birth*

☐ **Consent to Treatment:** The purpose of this consent is to obtain permission from the patient's parent or legal guardian for the provision of health care services. Except in those limited situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent, the Adolescent Clinic must have a written, signed consent from a parent or legal guardian prior to providing health care services to the Student.

By my signature below, I hereby request and authorize that the patient may:

(1) **receive health care services available from, and deemed necessary by, the Adolescent Clinic, which services may include, but shall not be limited to, the administration of medication, treatment of acute illnesses and injuries, wellness check-ups, and immunizations;**

(2) **receive referral care and emergency transportation to other health care providers, as deemed necessary by the Adolescent Clinic;** and

(3) **participate in surveys on a volunteer basis.**

☐ **Consent to Disclose Records:** Records maintained by the Adolescent Clinic are considered "education records" and, as such, are governed by the Federal Family Educational Rights and Privacy Act ("FERPA"). The purpose of this consent is to obtain permission, in accordance with FERPA, from the Student's parent, legal guardian, or the Student, if the Student is 18 years or older, for the disclosure of the Student's education records related to those health care services provided by the Adolescent Clinic.

By my signature below, I hereby request and authorize the Adolescent Clinic to:

(1) **release information related to health care services provided to the patient to the appropriate third-party payor for payment purposes;** and

(2) **exchange information pertaining to the patient's School Entrance Health Form, and related immunizations and school entrance physicals, for the purposes of fulfilling the Commonwealth of Virginia's immunization compliance requirements.**

The above checked consents are authorized for the length of time the Student is enrolled at _____. I may choose to withdraw either or both consents at any time. Any consent withdrawal must be communicated, in writing, to the Adolescent Clinic. I understand that even if I, as the patient's parent or legal guardian, withdraw consent for the patient to receive health care services at the Adolescent Clinic, the patient may still seek treatment in those situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent.

_____ _____

Patient Signature *Date*

_____ _____

Parent's / Legal Guardian's Signature *Date*

CARILION Children's

PATIENT IDENTIFICATION