



## School Based Health Center Registration Form

To be completed by Parent, Legal Guardian, or Student 18+

### PATIENT INFORMATION: (Please complete all sections)

School name: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's legal name: \_\_\_\_\_

Child's date of birth (month/day/year): \_\_\_\_\_

Sex: M / F

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

County or city: \_\_\_\_\_

Email: \_\_\_\_\_

Parent or guardian name: \_\_\_\_\_

Best phone number to reach parent: \_\_\_\_\_

We collect information on our patients to help us know more about the community we serve and to improve our services. We report this information without identifying patients personally. For example, we report that we serve 100 veterans.

What is your child's race? Check all that apply.

☐ American Indian or Alaska Native

☐ Asian

☐ Native Hawaiian or other Pacific Islander

☐ Black or African American

☐ White

☐ Other Race

☐ Unreported/Refused to Report

Circle appropriate answer:

Ethnicity: Hispanic / Non-Hispanic / Other \_\_\_\_\_

Homeless: Yes/No

How many people are living in your household, including yourself? \_\_\_\_\_

What is the estimated total annual income for your household, including government assistance and disability?

☐ Choose not to disclose ☐ Under \$11,000

☐ \$11,001 - \$15,00 ☐ \$15,001 - \$20,000

☐ \$20,001 - \$25,000 ☐ \$25,001 - \$35,000

☐ \$35,001 - \$45,000 ☐ \$45,001 - \$55,000

☐ \$55,001 - \$65,000 ☐ \$65,001 - \$75,000

☐ \$75,001 - \$85,000 ☐ Over \$85,000

Would you like your child to be seen for any of the following?  
(Check all that apply)

☐ Well Child Check

☐ Sports Physical

☐ Vaccines

☐ As needed – sick appointments

### MEDICAL INFORMATION: (Please complete all sections)

Primary Care Physician's name: \_\_\_\_\_

Pharmacy: \_\_\_\_\_

Does your child take medications on a routine basis?

Yes \_\_\_ No \_\_\_ If Yes, please list: \_\_\_\_\_

Does your child have allergies (Seasonal, Antibiotics, Latex, Food, Medications)? If Yes, please list: \_\_\_\_\_

Does your child need antibiotics before dental treatment?

\_\_\_ Yes \_\_\_ No If Yes, please explain: \_\_\_\_\_

### INSURANCE INFORMATION

#### Medical Insurance (if have)

Primary Insurance Company: \_\_\_\_\_

Insurance plan ID: \_\_\_\_\_

Group number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Date of Birth (month/day/year): \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_

#### Dental Insurance (if have)

Does your child have Medicaid? \_\_\_ Yes \_\_\_ No

If Yes, include your child's ID number: \_\_\_\_\_

Is your child covered by Private dental insurance \_\_\_ Yes \_\_\_ No

If Yes, please fill out All the insurance information below:

Dental Insurance Company: \_\_\_\_\_

Insurance Company Address: \_\_\_\_\_

Dental Insurance Plan: \_\_\_\_\_

Group Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder Address: \_\_\_\_\_

Policy Holder Date of Birth (Month/Day/Year): \_\_\_\_\_

Policy Holder SSN: \_\_\_\_\_

PLEASE COMPLETE OTHER SIDE

RETURN BY 8-26-2025



## SCHOOL BASED HEALTH CENTER (SBHC) PROGRAM CONSENT FORM

Dear Parent or Guardian,

The Rockbridge Area Health Center (RAHC) is expanding our service offering to the Rockbridge County Public School System (RCPS) for the 2025-2026 school year. In addition to dental services, we will also be providing medical and behavioral health services. The dental services will be provided as they have been for the previous 12 years at your child's school by licensed dentists and dental hygienists. Medical services will be provided by licensed independent practitioners and behavioral health services by a master's level Supervisee in Social Work under the clinical supervision of Mariah McMillan, LCSW and document review and co-signed by Scott Kleinert, LPC; Counselor in Residence under the supervision of Abigail Sorrells, LPC. Medical and behavioral health will be available at Maury River Middle School and Rockbridge County High School, but all RCPS students are eligible to receive services. A brief description of the services provided for each service is on the following page. For your child **to receive these services**, you must provide **ALL THE INFORMATION** requested, select the services you would like your child to receive and **SIGN** in the area indicated.

I understand that if my child requires SBHC services, reasonable attempts will be made to contact me and if I cannot be reached:

	I DO give	I DO NOT give
Dental	<input type="checkbox"/>	<input type="checkbox"/>
Medical	<input type="checkbox"/>	<input type="checkbox"/>
Behavioral Health	<input type="checkbox"/>	<input type="checkbox"/>

**consent** for my child to be seen by the providers at the SBHC. I understand if I cannot physically attend the appointment, I have the option to attend via audio (phone) or secure audio/video (telehealth).

### **IMPORTANT: PARENT/GUARDIAN SIGNATURE REQUIRED IF SERVICES ARE WANTED.**

I am a custodial parent or legal guardian of the minor child named below. I **authorize and consent to** this child receiving the services indicated above and allow the school nurse/ school representative and RAHC providers access to the child's health record and school record. Following the Health Insurance Portability and Accountability Act (HIPAA) rules, I **authorize and consent** to SBHC staff members using and sharing my child's personal health information (PHI) for 1) treatment of my child's health condition and maintaining the continuity of my child's care. 2) payment for health services provided to my child and 3) routine health care operations including quality improvement, accreditation, and educational purposes or other disclosures required by law.

**Student's Name:** \_\_\_\_\_

**CHECK ONE:** Parent \_\_\_\_\_ Legal Guardian \_\_\_\_\_

*If you are legal guardian, you must include a copy of guardianship documentation.*

**Printed Name of parent/legal guardian:** \_\_\_\_\_

**Relationship to student:** \_\_\_\_\_

**Signature of parent/legal guardian:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

Services provided at the school-based health center (SBHC):

**Dental Routine Exams (Provided at your child's school):**

- Exam
- X-rays
- Prophylaxis (teeth cleaning)
- Fluoride treatment
- Sealants (a protective coating on the chewing surfaces of back teeth)

If you currently take your child to see a dentist every 6 months for routine care, we encourage you to continue to seek care at that office and you do not need to select dental services on this form. TELL-SHOW-DO technique is often used to gain the confidence and cooperation of the dental patient. The dental provider explains what they are going to do, then shows what they are going to do with instruments on a model. Most patients do not encounter any difficulties with their treatment. If the patient indicates any strong resistance to the dental procedure, we will discontinue the treatment. You will be notified of the results of your child's visit.

**Medical (Provided at Maury River Middle School and Rockbridge County High School):**

- Physical exams (well-child, sports, work)
- Care and treatment for injury/illness
- Routine lab tests
- Care for common pediatric/adolescent health concerns (weight, acne, menstrual problems)
- Care of certain chronic conditions (such as asthma, seizure disorders, or diabetes)
- Vision and hearing screening and treatment
- Sexual wellness services
- Infectious diseases (flu, strep, COVID-19)
- Immunizations provided on a scheduled basis (12-24 hours from request)
- Nutrition counseling provided on a scheduled basis
- Referrals for services not provided at the SBHC

Copies of visit summaries will be provided to the patient portal and your PCP upon request.

**Behavioral/Mental Health (Provided at Maury River Middle School and Rockbridge County High School):**

- Behavioral/mental health assessment, screening, and intervention (additional parental/guardian consent required for children under the age of 18)
- Drug or alcohol use treatment










**Copies of visit summaries will be provided to the patient portal and other care team providers upon request, PCP, psychiatrist etc.**

RAHC will encourage every student to involve their parents/legal guardians in health care decisions, however, under Virginia law, children 14 and older can request mental health, substance use, and sexual health treatment without the consent of an adult.

Important information explaining Virginia law regarding adolescent proxy authorization to medical records is explained on the next page. By law RAHC is required to limit parental access to medical records, including the patient portal, when the patient turns 13, and restrict full access when the patient turns 18. Patients may authorize full medical record access to parents, by signing an authorization.

Proxy Access:



	<b>Partial Access</b> With partial access, parent(s)/guardian(s) can: <ul style="list-style-type: none"><li>• Update demographic information</li><li>• View office hours, locations, and providers</li><li>• View your child's immunization history</li><li>• View your account balance</li></ul>	<b>Full Access</b> With full access, parent(s)/guardian(s) can: <ul style="list-style-type: none"><li>• Access all partial access permissions</li><li>• Communicate with your practitioner</li><li>• View and request labs</li><li>• View your child's complete medical file</li></ul>
 <b>0 - 12 years old</b>	 Partial access does not apply.	 Full access is automatically given to parent/guardian.
 <b>13 - 17 years old</b>	 Previous full access is lost the day the patient turns 13 and partial access is given.	 Full access is given to parent/guardian if authorized by patient.
 <b>18 years +</b>	 Previous proxy access expires the day the patient turns 18.	 Full access may apply to adults including parent/guardian if authorized by patient.