MHHS SCHOOL BASED HEALTH
2023-2024 ENROLLMENT/ANNUAL UPDATE FORM

Dear Parent/Guardian,
Please complete the following form for our providers to have up to date information to best treat your child. You may contact us with any questions at 304-354-9732. **All children are automatically enrolled** at school-based health; if you wish to **opt out** of the program, please contact us for an opt out form.

STUDENT'S NAME_________________________________**DOB**__________________ **AGE** _______

ADDRESS ____

Primary Contact: □ ok to leave message
Name: ____ Relationship: ____________________
Email: ____
Phone (H) ______________________ (W)________________________ (C) _________________________

Secondary Contact: □ ok to leave message
Name: ____ Relationship: ____________________
Phone (H) ______________________ (W)________________________ (C) _________________________

Additional Contact: □ ok to leave message
Name: ____ Relationship: ____________________
Phone (H) ______________________ (W)________________________ (C) _________________________

CURRENT SCHOOL: ( ) CMHS ( ) Arnoldsburg Elementary ( ) Pleasant Hill Elementary

Grade _______ **Homeroom Teacher** ____

Medical/Surgical History ____

____

Medications ____

Allergies____

Primary Provider____________________________ **Pharmacy**_____________________________

Specialists ____

Please indicate if you would like your child to receive the following services through Minnie Hamilton School-Based Health:

____ Well Child Check – This is a once yearly visit to check in on your child's health and development. It includes measurements, a head-to-toe examination, immunization updates (if needed, consents would be sent home before immunizations are given), and discussion of any health care concerns. Support and education are also provided during this visit for your child's overall health and well-being.

CONTINUED ON BACK

____ **Behavioral Health Evaluation -** This is a one-time evaluation to see if your child could benefit from one-on-one therapy. If one-on-one therapy is needed, you will be contacted to discuss therapy options. This evaluation is not needed if your child is currently receiving behavioral health treatment with MHHS or at another agency.

BEHAVIORAL HEALTH:

Behavioral Health History (include any diagnosis): ____

Current Behavioral Health Medication: ____

Current Therapist: ____ **Agency:** _________________________

HEALTH INSURANCE:

Primary Health Insurance (Please send copy of current card **OR** fill out information below)

Check if no health insurance: _________

Health Insurance Provider: ____

Group number:______________________________ ID number: __________________________________

Medicaid: Health Plan Unicare Carelink Aetna Other______________ (Please circle one)

Medicaid Number: ____

Name of insured parent/guardian: ____

Birthdate of card holder: ______________________________ SSN of cardholder: ___________________

Address (if different from child): ____

Secondary Health Insurance (if applicable)

Health Insurance Provider: ____

Group number:______________________________ ID number: __________________________________

Medicaid: Health Plan Unicare Carelink Aetna Other______________ (Please circle one)

Medicaid Number: ____

Name of insured parent/guardian: ____

Birthdate of card holder: ______________________________ SSN of cardholder: ___________________

Address (if different from child): ____

____ _______________________

Signature of Parent / Legal Guardian **Date**