



**Minnie Hamilton Health System**

**GILMER COUNTY SCHOOL BASED HEALTH**

**ENROLLMENT/ANNUAL UPDATE FORM**

Dear Parent/Guardian,

Please complete the following form in order for our providers to have up to date information to best treat your child. You may contact us with any questions at 304-462-3415. **All children are automatically enrolled** and able to be seen at school based health; if you wish to **opt out** of the program, please contact us or the school for the opt out form.

STUDENTS NAME \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS/PHONE \_\_\_\_\_

Father: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Mother: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

CURRENT SCHOOL: ( ) Gilmer County High School ( ) Gilmer County Elementary School

GRADE/HOMEROOM TEACHER \_\_\_\_\_

MEDICAL/SURGICAL/DENTAL HISTORY \_\_\_\_\_

MEDICATIONS \_\_\_\_\_

ALLERGIES \_\_\_\_\_

PRIMARY PROVIDER \_\_\_\_\_ PHARMACY \_\_\_\_\_

DENTIST \_\_\_\_\_ ORTHODONTIST \_\_\_\_\_

**Please initial below if you would like your child to receive the following services:**

\_\_\_\_ **Well Child Check** – This is a once yearly visit that updates you 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 is also provided during this visit for your child’s overall health and well-being.

\_\_\_\_ **Mental Health Evaluation**

CONTINUED ON BACK

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

Name of insured parent/guardian: \_\_\_\_\_  
Birthdate of card holder: \_\_\_\_\_ SSN of cardholder: \_\_\_\_\_  
Address (if different from child) \_\_\_\_\_  
Group & ID number: \_\_\_\_\_  
CHIP: Group and ID number: \_\_\_\_\_

Medicaid: Health Plan Unicare Carelink WvDow Other \_\_\_\_\_ (Please circle one)  
Medicaid Number: \_\_\_\_\_

**Check if no health insurance:** \_\_\_\_\_

**Secondary Health Insurance (if applicable)**

Name of insured parent/guardian: \_\_\_\_\_  
Birthdate of card holder: \_\_\_\_\_ SSN of cardholder: \_\_\_\_\_  
Group & ID number: \_\_\_\_\_  
CHIP: Group and ID number: \_\_\_\_\_  
Medicaid: Health Plan Unicare Carelink WvDow Other \_\_\_\_\_ (Please circle one)  
Medicaid Number: \_\_\_\_\_

**Dental Insurance**

Name of Insurance \_\_\_\_\_ ID # \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Parent / Legal Guardian**

\_\_\_\_\_  
**Date**