HERMISTON
STUDENT HEALTH CENTER

Student's Legal Last Name: _____ **First Name**: _____

Preferred Name:_____ **Pronouns:** _____

Grade Level: _____ **Birthdate**: _____ **Age:** _____ **Phone Number:** _____

What sex category is on your original birth certificate: ☐ Female ☐ Male ☐ Intersex

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't Know/Decline
Race: ☐Asian ☐ Black ☐ Native American ☐ Pacific Islander ☐ White ☐ Other ☐ Don't Know/Decline

Address: _____ **City**: _____ **State**: _____ **Zip**: _____

Primary Care Provider:_____**Last Visit Date:**_____

Dental Provider:_____**Last Visit Date:**_____

Vision Provider: _____ **Pharmacy:** _____

Parent/Guardian Emergency Contact Information

Name: _____ **Relationship**: _____ **Phone Number**: _____

Name: _____ **Relationship**: _____ **Phone Number**: _____

Consent for Services

I give permission for the Hermiston Student Health Center to provide medical and/or mental health services to the above-named individual*. I understand the following types of services are provided through the Health Center: Routine physical exams (including sport's physicals), assessment, diagnosis, and treatment of illness and injury, vision and dental screenings, routine lab tests, immunizations, health education, counseling, prescription medications, over the counter medications, mental health services, and referral for health care services not provided by the Health Center. I understand that these services may be offered in person or through electronic communications such as two-way video or voice phone call.

I understand that the Health Center is a collaboration between Health Center staff (employees from Umatilla County Public Health and Community Counseling Solutions) and Hermiston School District (HSD) Staff and that information regarding student well-being may be shared between Health Center and HSD staff for the safety, health, and overall academic success of the above-named individual. I also authorize and give permission to the Health Center to contact the above-named individual's personal care physician to share medical information regarding ongoing medical needs.

I authorize the release of any medical and protected health information necessary to process this claim and authorize payment of medical benefits for services by the Health Center. Insurance will be billed for services provided at the Health Center. Any services provided outside of the Health Center (such as pharmacy, radiology, or labs) are the responsibility of the parent and/or guardian.

The Hermiston Student Health Center is required by law to maintain the privacy of your health information. A copy of the Notice of Privacy Practices is available at ucohealth.net/hshc I understand the Health Center has the right to change this Notice at any time. A current copy is available upon request by contacting the Health Center.

I have read the above information and have had the opportunity to ask questions. This consent will remain in effect for one year from the date of signature. I understand I may revoke this consent at any time by providing a written notice to Health Center.

Signature: _____ **Relationship:** _____ **Date:** _____

*We support and encourage parental involvement in decisions about a child's health care. Oregon State Law requires the signature of a parent or guardian for medical treatment for students less than 15 years of age with the exception of family planning information and sexually transmitted infections. Oregon State Law requires the signature of a parent or guardian for mental health services, including drug and alcohol issues, if the child is less than 14 years of age. ORS 109.640, ORS 109.675.

HERMISTON STUDENT HEALTH CENTER

Student Name:_____ Birthdate:_____

Physicals are a key way to identify any potential health issues, as well as provide guidance for developing lifelong healthy behaviors. It is recommended by the American Academy of Pediatrics that students receive a physical each year. This can also serve as a sports physical exam. Would you like your student to receive an annual check-up at the Student Health Center this school year?:

☐ Yes, please schedule ☐ No thank you

Insurance Information

The Student Health Center is funded through third-party insurance, Medicaid, grants, and local support. Providing us with your insurance information allows us to bill your insurance and continue to provide the services to as many students as possible.

If your insurance company does not pay for all or part of the cost you are **not** responsible for any out-of-pocket expenses for services received at the Student Health Center.

Families with no health insurance or who do not provide insurance information are referred for screening to see if they qualify for the Oregon Health Plan or other insurance programs.

Oregon Health Plan / EOCCO

Policy/ID Number: _____

Private Insurance

Name of Insurance Company: _____

Insurance Company Phone Number: _____

Policy / ID Number: _____ **Group Number:** _____

Name of Policy Holder: _____ **Birthdate:** _____

Relationship to Student: _____

Does the student have secondary insurance? ☐ Yes* ☐ No

Name of Insurance Company: _____

Insurance Company Phone Number: _____

Policy / ID Number: _____ **Group Number:** _____

Name of Policy Holder: _____ **Birthdate:** _____

Relationship to Student: _____