laredo Kids clinic

crawford Kids clinic

Rocky Mountain Youth Clinics

Kids Clinic at Crawford and Laredo

Registration Form

Patient Information(Please print)

Last Name_____ First Name _____ Middle Name _____

Date of Birth(mm/dd/yy) ___/___/___ Sex: M F School: _____
(Where Student Attends)

Family Contact Information

Who does the child live with (check all that apply):

Mother___ Mother's Complete Name: _____ Date of Birth ___/___/___

Father ___ Father's Complete Name: _____ Date of Birth ___/___/___

Guardian ___ Guardian's Name: _____ Relationship: _____

Street Address: _____ Apartment #:_____ Aurora, Co Zip Code: _____

Home Phone # :(_____)_____ E-Mail: _____

Mother's Cell #: (_____)_____ Father's Cell #: (_____)_____

Mother's Work #: (_____)_____ Father's Work #: (_____)_____

Emergency Contact Information

Emergency Contact: _____ Relationship: _____ Phone #: (____)_____
(Aside from those that live at home)

Insurance Information

Medical Insurance: Medicaid CHP+ No Insurance Private Insurance(Name):_____

Identification #: _____ Group #: _____

Statistical Information

This section is optional; information is gathered for statistical purposes. Please ask for further information or assistance if you have question or concerns

Please circle your primary language:

English	Amharic	French	Italian	Polish	Vietnamese
Spanish	Arabic	German	Japanese	Russian	Sign Language
Chinese	Hindi	Korean	Other(Fill in):_____		

Please Check the category that you feel most accurately represents you background:

___ American Indian or Alaskan Native
___Asian
___Black or African American
___Do not wish to answer(check one)
___Hispanic
___Multiracial(Fill in): _____
___White

This School-Base Health Center is a collaborative efford among
Aurora public Schools, Rocky Mountain Youth Clinics, Aurora Mental Health Center

laredo Kids clinic

Rocky Mountain Youth Clinics

Kids' Clinic at Crawford and Laredo

Consent Form

crawford Kids clinic

Please Read the Following Information Carefully

I understand that medical and preventive dental services are provided by Rocky Mountain Youth Clinics.

I understand that mental health services are provided by Aurora Mental Health Center.

I authorize services to be delivered to my child as necessary. I understand that the school health staff or the Kids' Clinic staff will attempt to notify me prior to my child's encounter with the medical, mental health or dental health professional. I give permission for my child to receive care at the Kid's Clinic whether or not I can accompany my child to the clinic each time.

I authorize the Kids' Clinics staff to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including his/her primary care doctor or clinic, the school nurse or school health paraprofessional, Aurora Mental Health Center staff, Rocky Mountain Youth Clinics' staff and other Kids' clinic staff.

By signing below I give consent for my child's school health staff to bring my child to the Kids' Clinic if I am unavailable. I may authorize one other person I give consent to bring my child to the Kids' Clinic if I am unavailable.

Authorized Person (name) : _____ _____Relationship:_____

Authorized person's best phone number :(_____)_____

I authorize Kids' Clinic staff to contact emergency services (9-1-1) for my child if necessary. Any expenses related to ambulance or other emergency referral will be my responsibility.

I give consent to the Kids; Clinic staff to review my child's school records, attendance and other records that may assist Kids' Clinic providers to help my child.

I give consent to release any information regarding treatment to third party payers (insurance) for the purpose of billing. I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment, and my consent is given in light of this knowledge. I understand it is my duty to inform the Kids' Clinic staff of any change in the child's guardianship.

I give permission for my child to be transported from his/her school to or from the Kids' Clinic by APS school staff or Kids' Clinic personnel.

I also certify, by signing this form, that I am legally authorized to provide this consent. This consent will remain in force for a period of one year, or until I revoke said consent in writing.

_____	_____	_____
Parent/Guardian Signature	Parent/ Guardian PRINTED Name	Date

My signature below is acknowledgment that I have seen and read the Kids' Clinic HIPAA Notice of Privacy Practices.

_____	_____	_____
Parent/Guardian Signature	Parent/ Guardian PRINTED Name	Date