

**BRANDON WELLNESS CENTER  
PHILIP BARBOUR HIGH SCHOOL  
99 HORSESHOE DRIVE  
PHILIPPI, WV 26416  
304-457-4000**

**STUDENT INFORMATION AND PARENTAL/GUARDIAN CONSENT FORM**

<b><u>STUDENT INFORMATION:</u></b>	Student I.D. # _____
First Name: _____ MI: _____ Last Name: _____	
Mailing Address: _____	
City: _____ State: _____ Zip Code: _____	
Date of Birth : ____/____/____ Social Security Number: ____/____/____	
Gender: Male ___ Female ___ Grade: _____	
Name(s) of Parent(s)/Gaurdian(s): _____	
Telephone: Home: _____ Work: _____ Cell: _____	
<i>If we are unable to reach the Parent or Guardian, please list another emergency contact.</i>	
2nd Emergency Contact: _____ Telephone: _____	
Relationship to Student: _____	

<b><u>MEDICAL INFORMATION:</u></b>
Who is the student's regular physician? _____
Is the student allergic to any medications? Yes ___ No ___ If yes, please list: _____
Is the student taking any prescribed medications on a regular basis? Yes ___ No ___ If yes, please list medication and dose: _____
When was the student's last Tetanus shot? _____
Is there other medical information regarding the student that should be noted? _____
_____
_____

*Please complete the reverse side of this form*

**INSURANCE INFORMATION:**

Do you have private insurance? Yes \_\_\_ No \_\_\_

*If yes, please attach a copy of the insurance card to this form and complete the following:*

Name of Insured: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of insurance company \_\_\_\_\_

Insured's Social Security Number: \_\_\_/\_\_\_/\_\_\_ Insured's Date of Birth: \_\_\_/\_\_\_/\_\_\_

Policy Number: \_\_\_\_\_

Do you have a Medicaid Card for the student issued by the Department of Health and Human Services?

Yes \_\_\_ No \_\_\_ If yes, please write down card number (the MAID#): \_\_\_\_\_

Is the student covered under WV CHIP?: Yes \_\_\_\_\_ No \_\_\_\_\_

Is the student eligible to receive free or reduced-priced meals at school? Free: \_\_\_ Reduced: \_\_\_ No: \_\_\_

***I, the parent or guardian of the student listed on this form, do hereby consent for (Him/Her) to receive treatment and/or medical services at the Brandon Wellness Center at Philip Barbour High School. I understand the Notice of Privacy Practices for the Center.***

Please indicate the period of time for the consent to be effective:

*While the student is enrolled at Philip Barbour High School: \_\_\_\_\_*

*For the following school year(s) only: 20 \_\_\_ to 20 \_\_\_*

Please indicate which services you would like to be notified about:

*Full services \_\_\_\_\_*

*Free services \_\_\_\_\_*

Please indicate if you would like for us to perform a yearly physical on the student:

*Yes \_\_\_\_\_ No \_\_\_\_\_*

***I, the parent or guardian of the student listed on this form, furthermore, do understand that I am responsible for all fees incurred for services provided to the student.***

Parent's or Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_