HealthHUB

Frank Lamson, CPNP

Chelsea Public School	Sharon Elementary School	South Royalton School	Tunbridge Central School
Charlotte Faccio, RN	Ellen Bald, RN	Carol Jarmy, RN	Susan Hull, RN
685-4551	763-7425	763-3203	889-3310

I give permission for my child______________________________ to be enrolled at HealthHUB. The following services are available at school and are provided by Frank Lamson, Certified Pediatric Nurse Practitioner, South Royalton Health Center, 763-7575.

Physical exams/immunizations
Prescriptions (written or called to pharmacy)
Nutrition and weight counseling
Referrals to other health care professionals
Treatment of acute illnesses and sports injuries
Mental health counseling
Dental screening

I agree that my health insurance company will be billed by the South Royalton Health Center for medical services rendered at HealthHUB. Payments and co-payments will be made directly to the South Royalton Health Center. I understand that HealthHUB will provide medical information to my insurance company as necessary to bill and substantiate the services that my child received. I understand that I will be billed for any charges not covered by my health insurance. If my health insurance company requires a primary care physician referral for a visit to HealthHUB, it will be my responsibility to obtain it. I will notify HealthHUB of any changes in my health insurance coverage.

I agree that HealthHUB may obtain necessary information from the school health record and/or school nurse.

I understand that HealthHUB will provide medical information to my child's primary care physician and referral health providers as necessary to continue my child's medical care.

I understand that permission for enrollment may be withdrawn at any time with written notification to HealthHUB.

Every effort will be made to keep parents/guardians informed about the care provided to their child.

Signature of Parent/Guardian____ Date________________

Student Information **School**

Name__________________________________ DOB____________ SS#______________________ Sex___

Address____ PH#____________________

PrimaryCareProvider____ PH#______________________

Parent Information

Parent/Guardian Name_______________________________________ PH#___________________________

Address____

Insurance Information

Insurance Company____ Policy#_________________________

Subscriber____ Group#_________________________

Insurance Company PH#______________________ Vt Medicaid/Dr.Dynasaur#______________________