HSC's Dr. Robert E. Appleby School Based Health Centers
Registration Form _NHS
_BMHS _Briggs

Please complete all information on the front and back of this registration form. You must sign and date it in order for your student to receive services from the School Based Health Centers. If a student is 18 or older, he/she can sign his/her own registration form.

Grade: **Date of Birth: ____**

Student's Name: Sex: F M

Address: _City: Zip Code:

Home Phone: Cell phone Work Phone

Emergency Contact Person:

Contact Name:	Phone #:	Relationship:
Contact Name:	Phone #:	Relationship:

Ethnicity of student (Per Federal OMB Guidelines): Please circle one.

Hispanic/Latino(a) Not Hispanic/Not Latino(a)

Race of student (Per Federal OMB Guidelines): Please circle one.

White Black Amlndian/Alaska Native Native Hawaiian or other Pacific Islander Asian

If Race of student is NOT listed above, kindly write in here:

Mother's Name_ Daytime phone #_

Father's Name _ Daytime phone #

If not parents, whom do you live with?_____

Please indicate your relationship to student: __ Guardian ___ Other

Source of Medical Care:

Who is your child's doctor/clinic: Phone:

Where do you *usually* bring your student for medical care?

_Community Health Center
_ Emergency Room
_Health Department Clinic
_Hospital Clinic/Outpatient
_Military Clinic
_ Private MD
School Based Health Clinic
JJrgent Care Clinic
_Mobile Van _None
Other