Children's Hospital School Based Telehealth Program Enrollment Form

Children's Hospital New Orleans LCMC Health

***This enrollment form will be used for reference at the time of your child's video visit.**

General Information

Student Name: _____ _____ _____
Last First M

Student Date of Birth: _____ **Sex:** ☐ **Male** ☐ **Female**

Primary Care Provider: _____
Parent / Guardian Name: _____
Relationship to Student: _____
Parent / Guardian Email: _____

Student's Primary Information:

Address: _____
City: _____ **State:** _____ **Zip:**_____
Primary Phone*: _____ **Secondary Phone:** _____
***We will call this number if a video visit is needed** ☐ **Home** ☐ **Cell** ☐ **Work**
☐ **Home** ☐ **Cell** ☐ **Work**

Payment / Insurance Information:

Note that the visit is only billed upon successful completion of the video visit. If this information changes without notification or is incorrect, a bill may be sent to the address above.

☐ **Medicaid Number:** _____
Medicaid Plan: _____

☐ **Private Insurance Plan:** _____
Policy Number: _____

Name of person under whom student is insured: _____
Relationship: _____ **DOB:** _____

☐ **No Insurance**
Note that the video visit will be billed to the parent / guardian listed above

Please list any:

Known Allergies:
1._____
2._____
3._____

Current Medications:
1._____
2._____
3._____

Major Medical Procedures or Events:
1._____
2._____
3._____

By submitting this form, I acknowledge that my child's information may be entered into the Children's Hospital EMR.

Parent/Guardian Signature:_____ **Date:**_____