MONONGAHELA VALLEY ASSOCIATION OF
MVA HEALTH CENTERS

MVA Health Center - Fairmont | P.O. Box 1112 | Fairmont, W.V. 26555 - 1112 | (304) 366-0700

Student Insurance Information

Name of insurance company:_____ Policy holder name:_____

Policy or Medicaid Number: _____ Group Number:_____

_____Check here if the student does not have insurance.

By signing below, I understand and acknowledge the following: 1) I give permission for my student to be treated by the Wellness Center Staff; 2) I accept responsibility for payment of charges incurred for services rendered to my dependent.

Parent or Legal Guardian signature:_____

Student signature if over 18 years of age:_____

Printed name:_____ Today's Date:_____

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MVA School Based Health Centers Parent/Guardian Consent Form

Student/Patient Information:

Name:_____ Date of Birth: _____

Address:_____ Grade: _____

City:_____ Sex: _____ Male _____ Female

Parent/Guardian Name:_____ Relationship:_____

2nd Emergency Contact name:_____ Relationship:_____

Parent phone number:_____ Emergency contact phone number:_____

School Attending: _____ North Marion High

_____ East Fairmont High

Student Health Information:

Allergies:_____ Medications:_____

Medical conditions: _____

Where does the student primarily obtain medical care?

_____ MVA Fairmont Clinic

_____ My student does not have a primary care physician

_____ Other, please list name of provider here _____

_____ **Check here if you would like your student to have an Annual Well Child Exam at the school.**
If yes, please list date of last well child exam: _____