Gerald Champion Regional Medical Center
Our Family Caring For Yours

Name: (Last, First, MI)	Age:	Sex: M F	Birth Date:
Street Address:	City:	Zip	SS#
Mailing Address:	City:	Zip:	
Primary Care Provider:	Pharmacy:		
Current School Year:	School Name:		

PARENT/LEGAL GUARDIAN

Name: (Last, First, MI)	Birth Date:		
Street Address:	City:	Zip:	
Cell Phone:	Work Phone:	Email Address	SS#:
Employer:	Address:		

In Case of Emergency (Friend or Relative not listed above. ONE MUST BE LOCAL)

Name (1): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:
Name (2): (Last, First)	Address:	
Home & Cell Phone:	Work Phone:	Relation:

INSURANCE INFORMATION (A copy of ALL Insurance cards is required for filing purposes.)

Primary Insurance:		Name of Insuree & SS#:
Group #:	Insured's DOB:	Insurance ID#
Secondary Insurance:		Name of Insured & SS#:
Group #:	Insured's DOB:	Insurance ID#

DATE

SIGNATURE of PARIENT/LEGAL GUARDIAN OF MINOR

** Please email form to ******* upon completion

This form must be on file before student can access the Telehealth visits

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