WVU Medicine
WEIRTON MEDICAL CENTER

651 Colliers Way, Box 300 I Weirton WV 26062 I 304-797-6200

Parents of Allison and New Manchester Elementary School Students:

WVU Medicine WMC Physician Practices partners with the Allison and New Manchester Elementary Schools to offer an in school health clinic for Allison students.

Allison Health Clinic (AHC) will operate from 9 am -1 pm on regularly scheduled school days. The clinic will be staffed by Dr. Lisa Noble, Pediatrician and Gina Kelley, Nurse Practitioner.

AHC offers students with medical services similar to what would be provided at a normal physician office visit. AHC will not provide any medications. Any medication distribution to students will continue to be provided through the Allison school nurse office.

Should your child need additional medical services, the AHC will contact the primary care physician office listed on your child's information form.

Your child's visit will be billed to the insurance provided on the attached information form and will be the same as any physician office visit. If you do not have insurance, you may be billed directly for the visit at a discounted rate.

In order to allow AHC to treat your child while at school, we need each parent to complete the attached form and sign the consent to treat section. Both parents will need to sign and date this form and return to the school office.

This program is a great addition to our school and we are pleased to be able to offer it to the Allison and New Manchester Elementary Schools. Please feel free to stop by the school office with any questions.

Sincerely,

ENROLLMENT AND CONSENT FORM

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Patient Name: _____ SSN: _____

Address:_____ City: _____ State/Zip: _____

Phone: _____ Grade: _____ Birthdate: _____ School _____

Lives Wlth: ____ Mother ____ Father ____ Both Other: _____

Primary Care Provider/Pediatrician:_____

Gender: Female or Male Ethnicity *(please check one):* Hispanic Not Hispanic Unknown Decline

Race: *(please circle one):* White Black/African American Asian American Indian Pacific Islander Other

PARENT/GUARDIAN CONTACT INFORMATION

Father: _____ Phone(H): _____ (W) _____

(Cell): _____ E-mail: _____

Mother: _____ Phone(H): _____ (W) _____

(Cell): _____ E-mail: _____

Guardian: _____ Phone(H): _____ (W) _____

(Cell): _____ E-mail: _____

Alternate Contact: _____ Phone(H): _____ (W) _____

(Cell): _____ E-mail: _____

Patient's Insurance Coverage

Primary Health Insurance:

Name of Insured Parent/Guardian: _____

Birthdate of Card Halder: _____

Address (If different from child): _____

Place of Employment: _____

Name of Insurance Company: _____

Insurance Address: _____

Insurance Phone/Fax Number: _____

Group & ID Number: _____

Secondary Health Insurance

Name of Insured Parent/Guardian: _____

Birthdate of Card Holder: _____

Address (ff different from child}: _____

Place of Employment: _____

Name of Insurance Company: _____

Insurance Address: _____

Insurance Phone/Fax Number: _____

Group & ID Number: _____

Medicaid:

Medicaid Insurance Company Name: _____

Medicaid#: _____ Member ID#: _____

PCP/HMO Provider: _____ Provider Phone Number: _____

CHIP: Name on card: _____ Birthdate of Card Holder: _____

IO or PIN I on Card: _____ Group #: _____