



HEALTH AND WELLNESS CENTER at CENTENNIAL HIGH SCHOOL
SUMMER 2017 - REGISTRATION FORM

THE HEALTH & WELLNESS CENTER
 AT CENTENNIAL HIGH SCHOOL

Date: _____

1. STUDENT INFORMATION

Last Name:		First Name:	Middle Name:
Date of Birth (mm/dd/yy) ____/____/____		Sex: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Student ID #
Mailing Address:			
City:		State:	Zip Code:
Cell Phone:	Email:		SSN:
Please circle the category that most accurately represents the student's background:			
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Asian	<input type="checkbox"/> Black or African American
<input type="checkbox"/> Native Hawaiian or Pacific Islander		<input type="checkbox"/> White	<input type="checkbox"/> Multi/Other/Undetermined
		<input type="checkbox"/> Do not wish to answer	
Does the student consider him/herself Hispanic/Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Bilingual, please list the languages spoken:			

2. FAMILY INFORMATION (Please Print)

Parent/Guardian, Last and First Name:			
Relationship:	Cell:	Work:	
Email:			
Mailing Address:			
City:		State:	Zip Code:

Parent/Guardian, , Last and First Name:			
Relationship:	Cell:	Work:	
Email:			
Mailing Address:			
City:		State:	Zip Code:

3. Preferred Method to receive communication (Please Circle)

Phone Text Email US Mail

4. EMERGENCY CONTACT (if we are unable to reach the parents/guardians listed above)

1. Name:	Relationship:	Cell:	Work:
2. Name:	Relationship:	Cell:	Work:

CONTINUED – SEE NEXT PAGE



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5. HEALTH INSURANCE INFORMATION: *Please bring insurance card or a copy of both sides to your appointment.*

Check all that apply

<input type="checkbox"/> Medicaid -		
Primary Insured Name:	Identification #:	Group #
<input type="checkbox"/> CHP+ -		
Primary Insured Name:	Identification #:	Group #
<input type="checkbox"/> Private Insurance - Name of Company:		
Primary Insured Name:	Identification #:	Group #
<input type="checkbox"/> No Insurance		
Number of people who live in your household: _____		
What is your family's gross total yearly income (before taxes): \$_____ /year		
I confirm that my student does not have health insurance that will cover services s/he is receiving and to the best of my knowledge, the family financial information listed above is complete and correct. _____		
Signature of Parent/Guardian (or Student if 18+)		

If necessary, may we contact you regarding health insurance information? Yes No

How did you hear about the Center? (Please circle all that apply):

- Poster
- Flyer
- PSD Website
- School Newsletter
- School Website
- Word of Mouth
- Back to School Night
- School Referral from: Teacher Coach Athletic Director Counselor Office Staff
- Other: _____