Owyhee Community Health Facility
A governmental entity of the Shoshone-Paiute Tribe
Contract Health Services
P.O. Box 130
Owyhee, NV 89832
Phone: (775) 757-2415
Fax: (775) 757-3929

STUDENT HEALTH FORM

THIS SECTION IS TO BE COMPLETED BY THE STUDENT

NAME: _____ _____ _____
LAST *FIRST* *MI*

DATE OF BIRTH: _____ CHART NUMBER: _____

TRIBE: _____ ENROLLMENT NUMBER: _____

INSURANCE NAME: _____

ADDRESS: _____ *PHONE NUMBERS NEEDED WHILE ATTENDING SCHOOL*

_____ HOUSING TELEPHONE #: _____

_____ CELL PHONE #: _____

EMERGENCY CONTACT INFORMATION

PERMANENT ADDRESS: _____ NAME: _____

_____ PHONE #: _____

_____ RELATIONSHIP: _____
(Mother, Father, Brother, Sister, etc.)

LIST ALL DEPENDENTS WHO WILL ACCOMPANY YOU WHILE ATTENDING SCHOOL

NAME:	DOB:	CHART #:	RELATIONSHIP:

I give permission for the ( ) to release the specified information to the recipient listed above.
I certify that my consent for disclosure of this information is entirely voluntary.

THIS SECTION IS TO BE COMPLETED & MAILED BY THE REGISTRAR'S OFFICE

I CERTIFY THAT _____ IS ATTENDING THE ABOVE SCHOOL AS INDICATED.

CHECK OFF WHICH SEMESTER

☐ SPRING SEMESTER

☐ FALL SEMESTER

CHECK OFF

☐ FULL TIME – STUDENT

☐ PART TIME – STUDENT
*Must have **12 Credits** to Qualify Per Semester*

CREDIT HOURS _____

REGISTRAR'S OFFICE SIGNATURE: _____ DATE: _____

AUTHORIZATION FOR MANAGED CARE TO OBTAIN CREDIT HOURS: _____

*IN ACCORDANCE WITH **42 C.F.R. § 136.23 (c)**, STUDENT HEALTH FORM MUST BE ON FILE TO RECEIVE HEALTH SERVICES WHILE IN ATTENDANCE AT AN EDUCATIONAL INSTITUTION.*

RECEIVED BY MANAGED CARE ON _____ APPROVED BY MANAGED CARE COMMITTEE ON _____
DATE *DATE*