



## **REQUIRED HEALTH FORMS CHECKLIST FOR NEW STUDENTS**

*Please return this packet to CRMS by **July 15, 2010** ALL FORMS MUST BE COMPLETED BEFORE ARRIVING AT CRMS.*

### **\_\_\_\_\_ Permission for Medical Care and Authorization for Release of Information/General Information Form**

*Students may not go on Wilderness or attend any active programs without this form completed.*

### **\_\_\_\_\_ Private Insurance Coverage Information Form**

*Please include a copy of the front and the back of your insurance card. Cut out and paste the copy on the form.*

### **\_\_\_\_\_ Report of Student Medical History Form**

*Please complete the front and back of this form and take it with you to your sports physical.*

### **\_\_\_\_\_ Physical Examination Form**

*This form is required **EACH** year for all CRMS students. It must be completed by a non-parent physician **BEFORE** any participation in active or Wilderness. It is absolutely necessary to get a physical before arriving at CRMS. **Please do not expect your student to be able to get a physical upon their arrival here.***

### **\_\_\_\_\_ Permission for Influenza Vaccine and Consent for Medications Form**

*The CRMS Health Office offers flu shots once each year. If you want your student to have a flu shot please make sure you sign this form.*

### **\_\_\_\_\_ Ophthalmologist or Optometrist Report Form**

*If your student wears glasses or contacts it is highly recommended this form is filled out by your eye doctor and kept at school should an emergency arise, e.g., broken glasses or lost contact lenses.*

### **\_\_\_\_\_ Permission for Prescribed Medication Form**

*If your student is taking any prescribed medications, this form must be filled out by the prescribing doctor. All prescribed medications must be kept in the CRMS Health Office unless an agreement has been made between the school nurse and parent. This is school policy.*

### **\_\_\_\_\_ Immunization History Form**

*Colorado law requires that this form be completed. If you are claiming a religious or personal exemption, please contact the school nurse to obtain an exemption form*

### **\_\_\_\_\_ Roaring Fork Family Physicians Forms**

*Please make sure this form is filled out **completely**. If your student is sick and in need of medical care, this form is necessary. Please do not wait until your child needs to be seen to fill this form out. Roaring Fork Family Physicians requires it for **EACH** student **EACH** year.*

### **\_\_\_\_\_ Notice of Privacy Policy**

*A hard copy of our privacy policy can be found on our website.*



## Permission for Medical Care and Authorization for Release of Information

*ALL forms MUST be fully completed, signed and returned to the Colorado Rocky Mountain School Health Office by July 15th in order to avoid any delays in your student's registration and for your child to participate in the Active Program. This includes all school activities and trips.*

I hereby give consent to Colorado Rocky Mountain School, or other instructional support staff associated with but not limited to Colorado Rocky Mountain School, to carry out accepted procedures for diagnosis, immunization, medical and surgical treatment, or counseling for my son/daughter/ward,

Please Print! \_\_\_\_\_  
Student's name: First Middle Last

(In rare instances a medical, surgical, or psychiatric emergency arises in which a written consent by the parent or guardian is legally required, but the proper person cannot be located. In such circumstances, in order to avoid delay which might jeopardize the life or recovery of a student, we also request the following permission from the parents or guardian, with the understanding that every effort will be made to contact them in an emergency.) I hereby grant permission to Colorado Rocky Mountain School, and other health care providers, including but not limited to Roaring Fork Family Physicians, Snowmass Clinic, Valley View Hospital, Aspen Valley Hospital, or if on a school trip, the nearest hospital emergency room to give medical care, emergency care, necessary anesthesia, and perform necessary surgery on my son/daughter/ward. I hereby grant permission to Colorado Rocky Mountain School and/or necessary medical personnel to have access to my son/daughter/ward's medical record in the event of admission to a medical facility. I hereby authorize the Colorado Rocky Mountain School Health Office who have provided health care services to my son/daughter/ward to release medical information (including information related to drug/alcohol treatment), as required to carry out treatment, health care operations, and payment, unless more specific authorization is required by law. I also authorize other health care providers who have provided medical treatment or related services to my son/daughter/ward, including, but not limited to Colorado Rocky Mountain School, to release medical information (including information related to drug/alcohol treatment) to the medical facility deemed necessary to carry out treatment and health care operations, unless more specific authorization is required by law. I authorize the release of medical information to my insurance company as may be necessary to determine benefits entitlement and to process payment claims for health care services rendered. When parents are separated or divorced, absent a court order to the contrary, Colorado Rocky Mountain School presumes that a non-custodial parent has access to health information and input to the same extent as a custodial parent. *My signature below indicates my consent to the above matters. This consent will remain in effect throughout the 2010-2011 school year unless it is revoked by me or my son/daughter/ward's other parent or guardian.*

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
SIGNATURE OF STUDENT

\_\_\_\_\_  
DATE

### PHARMACY PAYMENT:

I hereby authorize payment from my son/daughter/ward's Colorado Rocky Mountain School bookstore account to cover the pharmacy cost, designated by Colorado Rocky Mountain School, of any co-payments or unpaid balances after insurance, for medications provided to my child.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE



**General Information**  
*Please Print*

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_  
*(Please print) First Middle Last*

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Male \_\_ Female \_\_  
*(MM/DD/YYYY)*

**Parent's Information**  
*All information is needed in case of an emergency!*

Father's Name \_\_\_\_\_ Mother's Name \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_  
*No. Street No. Street*  
\_\_\_\_\_  
*City/Town State Zip Code Country City/Town State Zip Code Country*

Home Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Social Security # \_\_\_\_\_ Social Security # \_\_\_\_\_

Birth Date (MM/DD/YY) \_\_\_\_\_ Birth Date \_\_\_\_\_

Email \_\_\_\_\_ Email \_\_\_\_\_

Parents are: Married \_\_\_\_ Divorced \_\_\_\_ Separated \_\_\_\_

If parents are living apart, with whom does the student live? \_\_\_\_\_

Please list below two individuals who may take full responsibility for this student in the event neither parent can be reached.

Name \_\_\_\_\_ Name \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_  
*No. Street No. Street*  
\_\_\_\_\_  
*City/Town State Zip Code Country City/Town State Zip Code Country*

Home Phone (\_\_\_\_) \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_) \_\_\_\_\_



Colorado Rocky  
Mountain School  
est. 1953

### **PRIVATE INSURANCE COVERAGE INFORMATION**

*CRMS students are required to have health insurance coverage. For more information, visit our website.*

Student Name: \_\_\_\_\_ Social Security No: \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_

Identification No.: \_\_\_\_\_ Group No.: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Policyholder Last Name: \_\_\_\_\_ First Name & Initial: \_\_\_\_\_

Social Security No.: \_\_\_\_\_ D.O.B.: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Policyholder Employer: \_\_\_\_\_

Prescription Coverage: Yes \_\_\_\_\_ No \_\_\_\_\_

Does your insurance require pre-authorization? YES \_\_\_\_\_ NO \_\_\_\_\_

*Please notify the Colorado Rocky Mountain School Health Office should there be any changes in your insurance plan or coverage.*

### **PRIVATE INSURANCE AND PRESCRIPTION BENEFIT CARDS**

*Please make a clear copy of the front and back of your insurance card and prescription benefit card, cut them out, and attach them below.*



## REPORT OF STUDENT MEDICAL HISTORY

*(To be completed by Parent and Student)*

Student Name: \_\_\_\_\_

*Please Print*

Colorado Rocky Mountain School believes that the relationship among its students, parents, and its health care providers is strengthened by a mutual understanding of the basic rights and responsibilities of each of the parties. As such, ALL medical and psychological information shared between students and the CRMS Health Office is private and is treated confidentially within the limits of the law. CRMS strongly encourages students to develop relationships of trust with their Health Office and to be candid about their health histories and risk behaviors. We also encourage students to communicate with their parents on such matters. In this effort to promote candor and trust, CRMS Health Office asks that parents respect the privacy of students who may not wish to share certain information. While it is the obligation of every employee of CRMS to safeguard and keep student medical information confidential, the school must also balance matters of privacy and confidentiality with safeguarding the interests and wellbeing of our students and our community. Thus, parents and students consent to allow the CRMS Health office to disclose to those authorized employees of the school, who have a need to know, the minimum amount of medical and/or psychological information necessary to serve the best interests of the student and/or community.

**Personal History:** Please complete in full. COMMENT ON ALL POSITIVE ANSWERS IN THE SPACE PROVIDED OR ATTACH A SEPARATE SHEET.

Do you have or have you ever had...?	Yes	No	Comments
Any problems with hearing?			
Any problems with vision?			
Require glasses or contacts?			
Episodes of syncope or fainting?			
Have you ever fainted with exercise?			
Migraines?			
Tension headaches?			
Previous concussion or significant head injury?			
Seizures/Convulsions?			
Frequent infection of: Ears?			
Throat or tonsils?			
Sinuses?			
Allergic rhinitis (hay fever)?			
Asthma or episodes of bronchospasm/wheezing?			
Exercise-induced asthma?			
High blood pressure?			
Cardiac conditions: Palpitations or irregular heart rhythm?			
Heart murmurs that are not benign?			
Mitral valve prolapse?			
Other?			
Liver disorders, Hepatitis?			
Peptic or duodenal ulcer?			
Gastric reflux (heartburn)?			
Frequent diarrhea or blood in the stool?			
Ulcerative colitis or crohn's disease?			
Irritable bowel syndrome?			
Kidney disease?			

Frequent urinary tract infections?			
Kidney Stones?			
Anemia?			
Have you had mononucleosis?			
Have you had chicken pox (Varicella)?			
Chronic orthopedic or musculoskeletal conditions?			
Previous fractures?			
Previous joint dislocations?			
Joint pains or swelling without injury?			
Severe illness requiring hospitalization or prolonged incapacitation?			
Previous surgery?			
Chronic skin problems (acne, eczema, psoriasis, infection, hives)?			
Hormonal problems: diabetes, thyroid disease or other endocrine problems?			
Bleeding disorders?			
Cancer malignancy or tumor?			
Continuing or previous regular use of alcohol or illicit drugs?			
Have you been diagnosed with attention deficit disorder?			
Do you currently take medications for attention deficit disorder?			
Episodes of depression or bipolar disorder?			
Episodes of marked anxiety or nervousness?			
Episodes of obsessive-compulsive behavior?			
Have you ever been prescribed antidepressants, sedatives or other psychiatric medications?			
Do you currently take antidepressants, sedatives, or other psychiatric medications?			
Eating disorders (anorexia or bulimia)?			
Do you use tobacco products?			
Have you ever been exposed to tuberculosis?			
Have you ever received BCG? (please provide dates)			
Have you had a positive tuberculosis skin test in the past?			
Have you ever been on medications for tuberculosis?			
Do you have any restrictions to participation in athletics?			
Do you have any allergies to medications? If so, please state which medications and the nature of the allergic reaction.			
Do you have an allergies to food? If so, please list foods and the nature of the allergic reaction.			
Have you ever had an anaphylactic reaction to medication, food, or insect stings?			
If you have severe allergies, do you have an epi-pen?			
Have you received allergy injections in the past?			
Females ONLY: menstruation, age of onset?			
<b>Menstrual problems?</b> <b>Severe menstrual cramps?</b>			

If you answered yes to any of the personal history, please use this space to explain:\_\_\_\_\_

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**PHYSICAL EXAMINATION  
TO BE COMPLETED BY PHYSICIAN**

*(This is required for ALL students each year and must be completed before arrival at CRMS)*

Student Name \_\_\_\_\_ Sex: M\_\_ F\_\_ D.O.B.: \_\_\_/\_\_\_/\_\_\_  
(MM/DD/YYYY)

Height _____	Hearing ~ Right _____	Left _____
Weight _____	Vision ~ Uncorrected	Right _____
Blood Pressure _____		Left _____
Pulse _____	~ Corrected	Right _____
		Left _____

Are the following systems normal?	Yes	No	Abnormal findings
Skin			
Head, Eyes			
Ears, Nose, Throat			
Thyroid, Lymph nodes			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Genitourinary			
Hernia			
Back/Extremities			
Neurological			
Psychological			

Are there any significant medical problems not noted above? If yes, please describe:  
\_\_\_\_\_

TB test result from this physical or date of negative result within last year \_\_\_\_\_  
Date of last Tetanus shot \_\_\_\_\_ (if not within last 10 years, immunize now and write today's date)

Please list all prescribed Medications \_\_\_\_\_

Please list all medication allergies/reactions \_\_\_\_\_

Food allergies/reactions \_\_\_\_\_

Is there any reason to restrict physical activities? \_\_\_\_\_

Do you recommend any further evaluation or therapy? \_\_\_\_\_

Physician/ARNP/PA Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Date: \_\_\_\_\_





**OPHTHALMOLOGIST OR OPTOMETRIST REPORT**

*Only required if your student requires vision correction.*

Student: \_\_\_\_\_ Date: \_\_\_\_\_  
*Please Print*

We recommend that students wearing glasses or contact lenses have their annual eye examination before coming to school this fall. The following information is requested so that we can be most responsive should any emergency need arise, e.g., broken glasses or lost contact lenses. Student wearing contact lenses should also have a current pair of glasses for those situations that could preclude wearing contacts.

	<b>SPH.</b>	<b>CYL.</b>	<b>AXIS</b>	<b>ADD</b>	<b>PRISM</b>
<b>O.D.</b>					
<b>O.S.</b>					

Contact Lens Brand: \_\_\_\_\_

	<b>B/C SERIES</b>	<b>POWER</b>	<b>DIA.</b>	<b>PERIPH.</b>	<b>CURVES</b>	<b>CT.</b>	<b>COLOR</b>
<b>RIGHT</b>							
<b>LEFT</b>							

Ophthalmologist's or Optometrist's Name: \_\_\_\_\_

*(Please Print)*

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

## Permission Form for Prescribed Medication

Colorado Rocky Mountain School Health Office  
1493 County Road 106  
Carbondale, Colorado 81623  
970-963-2562, ext. 150 / fax 970-963-9865

**PLEASE MAKE COPIES AND FILL OUT A NEW FORM FOR EACH MEDICATION!**

Student Name: \_\_\_\_\_

→ ***To be completed by the physician or authorized prescriber***

Name of medication: \_\_\_\_\_

Medication indication: \_\_\_\_\_

Form of medication/ treatment:

\_\_\_\_\_ Tablet/ capsule    \_\_\_\_\_ Liquid    \_\_\_\_\_ Inhaler    \_\_\_\_\_ Injection    \_\_\_\_\_ Nebulizer    \_\_\_\_\_ Other

Instructions (schedule and dosage to be given at school): \_\_\_\_\_

Start:  date form received                      other date: \_\_\_\_\_

Stop:  end of school year                      other date/duration: \_\_\_\_\_

**OR:**  PRN

**Restrictions and important side effects:**  None anticipated

Yes, please describe: \_\_\_\_\_

Special storage requirements:                       None     Refrigerate     Other

Please add any pertinent additional information:

Date: \_\_\_\_\_                      Prescriber's Signature: \_\_\_\_\_

**Physician's Name:**

**Address:**

**Phone Number:**

**Email:**

→ ***To be completed by parent/guardian***

I have read and understand the Colorado Rocky Mountain School medication policy. I give permission for (Name of child) \_\_\_\_\_ to receive the above medication at Colorado Rocky Mountain School according to school policy.

Date: \_\_\_\_\_    Signature: \_\_\_\_\_    Relationship: \_\_\_\_\_



## IMMUNIZATION HISTORY

Student's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (MM/DD/YYYY)

### COLORADO LAW REQUIRES THIS FORM BE COMPLETE AND PROVIDED TO THE SCHOOL

**Diphtheria/Pertussis/Tetanus:** 4 doses provided 4<sup>th</sup> dose given on or after 4<sup>th</sup> birthday, and Td/Tdap booster every 10 years thereafter.

**Polio:** 3 doses of all IPV or OPV, provided last dose given after 4<sup>th</sup> birthday, or 4 doses of any combination IPV/OPV.

**Measles/Mumps/Rubella (MMR):** 2 doses required; 1<sup>st</sup> dose after 12 months of age.

**Tuberculin Test is required within one year prior to entrance.** If a student's skin test is positive, you must send a report of the chest x-ray results.

**Hepatitis B:** 3 doses required

#### **MUNIZATIONS AND TUBERCULIN TEST**

**Diphtheria/Pertussis/Tetanus:** Completed primary series of DTP/DTaP/Td/Tdap.

Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 4 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 5 \_\_\_\_/\_\_\_\_/\_\_\_\_

Is last Td/Tdap booster within the past 10 years? \_\_\_\_ Yes Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 \_\_\_\_ No **IMMUNIZE NOW!** Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Polio:** Completed primary series

Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_ OPV / IPV circle one  
 Date of dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ OPV / IPV circle one  
 Date of dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_ OPV / IPV circle one  
 Date of dose 4 \_\_\_\_/\_\_\_\_/\_\_\_\_ OPV / IPV circle one

**Measles/Mumps/Rubella (MMR):**

Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Tuberculin (PPD) Test:**

PPD within one year prior to entrance. \_\_\_\_ Yes Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_\_  
 \_\_\_\_ No **Skin Test Now!** Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result \_\_\_\_\_

If positive skin test: Date of chest xray \_\_\_\_/\_\_\_\_/\_\_\_\_ Medication \_\_\_\_\_  
 Result \_\_\_\_\_ Date started \_\_\_\_/\_\_\_\_/\_\_\_\_ duration \_\_\_\_\_

Previous BCG (yes/no): \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Hepatitis B:**

Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 3 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Meningococcal Vaccine:** (*Highly recommended for dorm students*)

Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_

**Varicella** (chicken pox) (*required if no history of disease*):

Date of disease (if had it) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 1 \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of dose 2 \_\_\_\_/\_\_\_\_/\_\_\_\_ (if given after age 13)

**Other Immunizations** (Hep A, typhoid, gardasil, etc)



**ROARING FORK FAMILY PHYSICIANS, P.C.**  
**1340 HWY 133, CARBONDALE CO 81623**  
**PHONE: 970-963-3350 FAX: 970-963-2958**  
**E-MAIL: [rffpmedrec@vvh.org](mailto:rffpmedrec@vvh.org)**

May 2010

Dear CRMS Parents:

Our Family Practice group has provided care for CRMS students since 1977. For the 2010-2011 school year, we are requiring the following payment procedure:

**1. A CREDIT CARD (VISA, MASTER CARD OR DISCOVER) must be on file before your child will be seen. WE DO NOT ACCEPT AMERICAN EXPRESS.**

**a. Fill out the credit card information on the registration form, attached.**

**b. YOUR CREDIT CARD WILL BE CHARGED FOR FULL AMOUNT OF SERVICES RENDERED EACH TIME YOUR CHILD IS SEEN FOR A VISIT.**

**2. INSURANCE:** See attached registration form for insurance information.  
**ENCLOSE A COPY OF THE FRONT AND BACK OF STUDENT'S INSURANCE CARD.**

**WE DO NOT BILL FOR PATIENT SERVICES; THEREFORE, IF A CREDIT CARD IS NOT ON FILE WITH OUR OFFICE, ALTERNATIVE ARRANGEMENTS WILL NEED TO BE MADE PRIOR TO YOUR CHILD BEING SEEN.**

If you have any questions, please call me and I will be glad to assist you.

Sincerely,

Keri Murphy  
Administrative Assistant  
Phone: 970-963-3561, Ext. 200  
FAX: 970-963-2958  
e-mail: [rffpmedrec@vvh.org](mailto:rffpmedrec@vvh.org)

**RICHARD A. HERRINGTON, M.D. GARY D. KNAUS, M.D. KIMBALL J. SPENCE, M.D. JOHN T. FINDLEY, M.D.  
ELIZABETH FLOOD SPIDELL, D.O. CATHERINE A. WHITE, FNP-BC IVY J. CARLSON, PA-C.**

**REGISTRATION FORM  
ROARING FORK FAMILY PHYSICIANS  
COLORADO ROCKY MOUNTAIN SCHOOL--PATIENT REGISTRATION FORM**

**STUDENT'S FULL NAME:** \_\_\_\_\_ **SEX:** MALE FEMALE

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SEC. #: \_\_\_\_\_

DATE OF LAST TETANUS SHOT \_\_\_\_\_ ALLERGIES \_\_\_\_\_

STUDENT'S CELL PHONE: \_\_\_\_\_

ONGOING MEDICATIONS \_\_\_\_\_

**RESPONSIBLE PARTY--PARENT/GUARDIAN**

**FATHER'S NAME:** \_\_\_\_\_ **HOME PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CELL PHONE#:** \_\_\_\_\_

\_\_\_\_\_ **WORK PHONE #:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

**MOTHER'S NAME:** \_\_\_\_\_ **HOME PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_ **CELL PHONE#:** \_\_\_\_\_

\_\_\_\_\_ **WORK PHONE #:** \_\_\_\_\_

**E-MAIL ADDRESS:** \_\_\_\_\_

A Credit Card (**VISA, MASTER CARD OR DISCOVER**) must be on file before your child will be seen.  
**(WE DO NOT ACCEPT AMERICAN EXPRESS!!!)**

*Your credit card will be charged for full amount of services rendered each time your child is seen for a visit.*

**CARDHOLDER: NAME:** \_\_\_\_\_ **CREDIT CARD#** \_\_\_\_\_

**EXPIRATION DATE:** \_\_\_\_\_ **3 DIGIT V-CODE ON BACK OF CARD** \_\_\_\_\_

**SIGNATURE OF CARDHOLDER:** \_\_\_\_\_

**INSURANCE: ENCLOSE A COPY OF THE FRONT AND BACK OF THE STUDENT'S INSURANCE CARD** showing policy number and mailing address for claims. We will file insurance for you and any remainder will be billed to your credit card unless other arrangements are made in advance. All charges will be considered out of network and no discounts given, unless you belong to Aetna, Cofinity, Cigna, Great West Health Care, Rocky Mountain Health Plans, Blue Cross/Blue Shield or United Health Care/Pacificare. For billing questions please contact Susie at scheney@rffpdocs.com.

**WE DO NOT BILL FOR PATIENT SERVICES; THEREFORE, IF A CREDIT CARD IS NOT ON FILE WITH OUR OFFICE, ALTERNATIVE ARRANGEMENTS WILL NEED TO BE MADE PRIOR TO YOUR CHILD BEING SEEN.**

**POLICY HOLDER'S NAME:** \_\_\_\_\_ **SOCIAL SECURITY #** \_\_\_\_\_

**POLICY HOLDER'S DATE OF BIRTH:** \_\_\_\_\_

**RETURN TO:**

ROARING FORK FAMILY PHYSICIANS, P.C.  
1340 STATE HWY. 133, CARBONDALE, CO 81623  
(ATTENTION--Keri)

Phone: 970-963-3561, Ext. 203  
Fax: 970-963-2958  
E-Mail: [rffpmedrec@vvh.org](mailto:rffpmedrec@vvh.org)



**Colorado Rocky Mountain School**

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I \_\_\_\_\_  
*Parent's name*

acknowledge having access to and reading a complete copy of the Notice of Privacy Practices on the CRMS website. This privacy notice is effective as of April 14, 2003. If you have any questions about the information in the Notice or would like to obtain a hard copy of the notice, please call the Health Office at 970-963-2562 ext. 150. Thank you.

\_\_\_\_\_  
*Signature of Parent or Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of CRMS Student*

\_\_\_\_\_  
*Date*

**PLEASE RETURN THIS PAGE TO THE CRMS HEALTH OFFICE**