Patient's Name_____ Sex_____ Date of Birth_____

Father's Name_____ Date of Birth_____ Present marital status_____

Place of Employment_____ Occupation_____

Mother's Name_____ Date of Birth_____ Present marital status_____

Place of Employment_____ Occupation_____

What is the child's living situation if not with both biological parents? (please circle)

Adoptive parents Foster family Joint custody Single custody with Mom or Dad (circle)

Patient's Sibling Child's Name (first and last) Sex Date of Birth Living at home?

1. _____
2. _____
3. _____

Birth History: Birth Weight_____ Full term? Yes No _____Weeks

Were there any issues with the pregnancy or after birth? Yes No (please explain)

_____

General Questions

	Yes	No	Details
Do you consider your child to be in good health?			
Does your child see a specialist or any health care professional?			
Has your child had any surgery?			
Has your child ever been hospitalized?			
Is your child allergic to medication or foods?			
Does anyone in the home smoke			

Patient Medical History

please mark any conditions the patient has

	Yes	No	Details
Problems with Ears or Hearing			
Problems with Eyes or Vision			
Asthma or wheezing			
Pneumonia, bronchitis, or bronchiolitis			
Heart problem or murmur			
Anemia			
Urinary Tract Infections or kidney problems			
Seizures			
Skin rashes, eczema, acne (circle)			
Depression			
Anxiety			

Patient history continued

	Yes	No	Details
ADHD or behavioral problems			
Learning or school problems			
Sleep problems or snoring			
Developmental or speech delay			
Bleeding Problem – too much or blood clots			
Thyroid disease or growth problems			
Metabolic or genetic diseases			
Other health problems (list details below)			

Additional details _____

Patient surgical history

Please circle any surgeries the patient has had

tonsils adenoids ear tubes appendix hernia
oral/teeth fracture reduction circumcision
other _____

Family History

please mark affected relatives with an X

	Mother	Father	Sibling	Grandparent	Other relative
Childhood hearing loss					
High blood pressure					
Heart Disease (heart attack, stroke)					
High Cholesterol					
Unexplained sudden death at young age (younger than 35 yrs)					
Asthma					
Bleeding Problem – too much or blood clots					
Substance Abuse – drugs or alcohol (circle)					
Depression					
Anxiety					
Diabetes					
Cancer					
Other health problems (list details below)					

Details _____

Current School _____ IEP or 504 plan (circle)

We treat you like family.

NORTHEASTERN VERMONT REGIONAL HOSPITAL

Permission For Medical Treatment

In the event that I cannot be contacted in a case of accident or illness, I hereby authorize Northeastern Vermont Regional Hospital to give appropriate medical attention to:

Name: _____

Date of Birth: _____ Social Security #: _____

Please Choose One:

- ☐ This authorization is valid for the following dates:
- ☐ This authorization is ongoing and will remain in effect unless and until revoked.

I give permission to the following individual(s) to allow _____ to seek medical treatment.

_____

_____

_____

_____

Please print the following information:

Parent or Legal Guardian Name	Health Insurance Company
Address	Name of Policy Holder
Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____	Policy Number _____ Group Number _____ Employer Name _____ Employer Address _____

_____ _____

Signature of Parent or Legal Guardian Date

Choosing Health
Northeastern Vermont Regional Hospital

NVRH PROXY ACCESS REQUEST & AUTHORIZATION FORM
Patient Portal Access -Minor Patient Under Age 18

1. Patient Information

Patient Name	Date of Birth	MRN# *(if known)*
Patient Address		

2. Proxy Information: (Person to whom you authorize NVRH to release the Patient Portal record)

Proxy Name	Date of Birth	Relationship to Patient
Address	Phone	
Preferred Email Address for Portal Account (please print):	Confirm Email Address (please print):	
Does the proxy have an active NVRH Patient Portal account? ☐ Yes ☐ No		

3. Type of Proxy Access Requested

☐ **Parent or Legal Guardian Requesting Access to Minor's Portal**
Under the HIPAA Privacy Rule (45 CFR §164.502(g)), a parent or legal guardian who has authority under applicable Vermont law to make health care decisions for an unemancipated minor is treated as the minor's personal representative and generally has the right to access the minor's PHI, unless a specific legal exception applies.

I certify that I am the minor patient's:
☐ Parent
☐ Court-Appointed Legal Guardian (attach current court order demonstrating valid authority)

I further certify:
☐ I have legal authority to make health care decisions for this minor.
☐ There is no court order, restraining order, or legal limitation restricting my access.

Important Notice Regarding Minor Confidentiality
Under Vermont law, minors may consent to certain types of care without parental consent. In those situations, the parent may not be the minor's personal representative for PHI related to that specific service. NVRH reserves the right, in accordance with 45 CFR §164.502(g)(5), to decline to treat a parent as a personal representative if, in professional judgment, doing so could endanger the minor patient.

These may include:
- Reproductive health services
- STI testing/treatment
- Substance use disorder treatment
- Certain mental health services
- Court-ordered services

Access to information related to those services may be restricted in accordance with Vermont and federal law.

Portal access configurations may be adjusted as the minor ages to comply with confidentiality requirements. Access determinations are based on applicable law and the nature of the service provided, not solely on age.

Choosing Health
Northeastern Vermont Regional Hospital

4. Authorization

By signing this proxy request:

- I authorize NVRH to provide the designated proxy access to the patient's protected health information (PHI) through the Patient Portal.
- Portal access may include, but is not limited to: health summaries, problem lists, medications, laboratory results, appointment information, and secure messaging.
- The information accessible through the portal may include sensitive health information, such as information relating to HIV/AIDS, sexually transmitted infections, reproductive health services, substance use disorder treatment, and mental or behavioral health services. Access to certain information may be restricted in accordance with Vermont or federal law.
- This authorization applies to information currently maintained and information created in the future, unless revoked.
- I understand that I may revoke this authorization in writing at any time. Revocation will not affect information already accessed prior to revocation. Revocation requests must be submitted to NVRH Health Information Management.
- I understand that information accessed by a proxy may be subject to re-disclosure and may no longer be protected by federal or Vermont privacy laws.
- I understand that refusal to sign this authorization will not affect the patient's ability to receive treatment; however, proxy portal access will not be granted.

Parent / Legal Guardian of Minor

I certify that I am the minor's parent or legal guardian with authority under applicable law and that the statements above are accurate.

Signature: _____ **Date:** _____

Relationship to Minor: _____

Proxy Acknowledgment (Required in All Cases)

I agree to comply with portal terms and safeguard login credentials.

Proxy Signature: _____ Date: _____