Bayhealth
Kent General · Milford Memorial

High School Wellness Center
Registration & Health History

Caesar Rodney Wellness Ctr.	302-698-4280
Dover Wellness Center	302-672-1586
Lake Forest Wellness Center	302-284-9291
Milford Wellness Center	302-424-6120
POLYTECH Wellness Center	302-697-8402
Smyrna Wellness Center	302-653-2399
Woodbridge Wellness Center	302-337-9310

Services **will not** be provided unless all sections of this form are complete. **(PLEASE PRINT CLEARLY IN INK)**

Student Name: _____ **Birthdate** _____/_____/_____ **Age:** _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Student Phone: (Home) _____ (Cell) _____ **Grade:** _____

Gender: ❒ Male ❒ Female **Ethnicity:** ❒Hispanic or Latino ❒Not Hispanic or Latino **Student's Preferred Language:** ❒English ❒ Spanish ❒ Other please list_____

Race: Please check ✓all that apply
❒American Indian/Alaska Native
❒Asian
❒Black/African American
❒Native Hawaiian/Pacific Islander
❒White/Caucasian

Name of Student's Medical Provider (Doctor): _____

Address: _____ Phone: _____

❒ **NO PHYSICAN OR MEDICAL PROVIDER**

Name of parent/guardian: _____Relationship to child_____

Parent/guardian Phone: (Home) _____(Cell) _____

INSURANCE INFORMATION IS REQUIRED TO PROCESS STUDENT VISITS AND A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED

Please indicate your medical coverage. ☐ **NO MEDICAL COVERAGE**

❒ **PRIMARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____/_____/_____ Relationship to child: _____

❒ **Medicaid#** _____

❒ **SECONDARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate:_____/_____/_____ Relationship to child: _____

❒ **Medicaid#** _____

A COMPLETE AND ACCURATE HEALTH HISTORY IS NEEDED IN ORDER FOR THE STAFF TO PROVIDE QUALITY HEALTH CARE.

ALLERGY HISTORY

❒ No Allergies

❒ Medication Allergy (please list): _____

Allergy to: ❒ Latex ❒ Peanuts ❒ Eggs ❒ Other (please list) _____

MEDICATIONS: Please list all medications child is currently taking: prescription, over the counter, herbal supplements

Name of medication Dose Reason for use

_____

_____

_____

FAMILY HEALTH HISTORY-Please check ✓ if any blood relatives (i.e. parents, grandparents, siblings) have had the following:

❒ High Blood Pressure
❒ Heart Disease/Heart Attack
❒ Kidney Disease
❒ High Cholesterol
❒ Overweight
❒ Diabetes (sugar)
❒ Thyroid Disease
❒ Sickle Cell
❒ Mental Health Concerns
❒ Stroke
❒ Asthma
❒ Tuberculosis
❒ Cancer

STUDENT HEALTH HISTORY

Please check ✓ any of the following conditions that your son/daughter has now or has had in the past.
Indicate with (P)-Past or (C)-Current. Please provide an explanation below for any **CURRENT** problem checked.

❒ Asthma
❒ Heart Problems
❒ Ulcers/Reflux
❒ Diabetes
❒ Head Injury/Headaches
❒ Seizures
❒ Physical Limitations
❒ Vision/Eye Problems
❒ Cancer (type)_____
❒ Anemia
❒ Tuberculosis
❒ Chicken Pox- year_____
❒ High Blood Pressure
❒ Skin Problems
❒ Weight Concerns
❒ Drug Use
❒ Alcohol Use
❒ Smokes/Chews Tobacco
❒ Learning Disability
❒ Frequent Anger
❒ Change in Friends
❒ Mood Changes
❒ Appears Withdrawn
❒ Attempted Suicide
❒ Anxiety/Depression
❒ Other (Please List)

Explanation of CURRENT illness or problems: _____

_____

List all past surgeries:

Type of Surgery	**Date**

Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness staff to address? ❒ Yes ❒ No

If yes, what are your concerns? _____

_____

Is your teen currently receiving counseling or mental health services: ❒ Yes ❒ No

Name of Counselor/Facility: _____

I have read this form carefully and ***I acknowledge*** that all information requested on the Registration & Health History Form is accurate and complete.

Signature of Parent/Guardian: _____ Date: _____