HEALTHY KIDS CLINIC
A Part of Cumberland Family Medical Center, Inc.

Healthy Kids Clinic Registration Form
Students

District: _____
School: _____
Grade/Teacher: _____
2022-2023 School Year

PATIENT INFORMATION
Please complete the following information about your child:

Child's Last Name: First: Middle: Date of Birth: Social Security #:

Sex Assigned at Birth: ☐ Male ☐ Female First & Last Name of ALL Parents/Guardians:

Street Address: PO Box: City: State: Zip:

Guardian Home Phone: Guardian Cell Phone: Guardian Work Phone:

Emergency Contact Name & Phone (Other Than Guardian):

What pharmacy do you use? City: Phone:

Language: ☐ English ☐ Spanish ☐ Other: Ethnicity: ☐ Hispanic or Latino ☐ Non Hispanic or Latino

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native ☐ Native Hawaiian ☐ Pacific Islander

As a Federally Qualified Health Center, Healthy Kids Clinic is required to collect the following information to ensure we are providing the appropriate medical care and financial assistance, as needed.

How many people live in your home? What is your annual household income?

Who is your child's primary care physician? Phone: Fax:

Would you like for your child's visit notes to be sent to their primary care physician? ☐ Yes ☐ No

MEDICAL INSURANCE INFORMATION

Primary Insurance Company Name: ID Number:

Group Number: Address of Policy Holder (if different than patient):

Whose name is on the policy? Policy Holder's Date of Birth: Relationship to Patient:

☐ Check this box if you do not have medical insurance. You may be contacted by our Patient Financial Services department.

Past Medical History

☐ No Past Medical History
☐ Asthma
☐ Anxiety
☐ Congenital Heart Defect
☐ Concussion or Head Trauma
☐ Depression
☐ Epilepsy/Seizures
☐ Hernia
☐ Sickle Cell Anemia
☐ RSV
☐ MRSA Skin Infection
☐ COVID-19 Date of Diagnosis _____
☐ Allergies
☐ Autism
☐ Cardiomyopathy
☐ Diabetes Type I
☐ Gastric Reflux
☐ High Blood Pressure
☐ Speech Disorder
☐ Meningitis
☐ Developmental Learning Disorder/Delay
☐ Other _____
☐ ADHD
☐ Anemia
☐ Cerebral Palsy
☐ Diabetes Type II
☐ Heart Murmur
☐ Hypothyroid
☐ Chicken Pox
☐ Smoking

Past Surgical History (with date included)

☐ No Past Surgical History
☐ Tonsillectomy: _____
☐ Adenoidectomy: _____
☐ Appendectomy: _____
☐ Ear Tubes: _____
☐ Incision and Drainage: _____
☐ Other: _____

Family History (Please label below with : **M** for Mother, **F** for Father, **S** for Sibling, and **G** for Grandparent.)

☐ Anxiety___ ☐ Asthma___ ☐ Congenital Heart Defect___ ☐ Cardiomyopathy___ ☐ Depression___
☐ Diabetes Type I___ ☐ Diabetes Type II___ ☐ Epilepsy/Seizures___ ☐ High Blood Pressure___ ☐ High Cholesterol___
☐ Hypothyroidism___ ☐ Heart Murmur___ ☐ Pacemaker___ ☐ Sickle Cell Anemia___
☐ Unexpected or unexplained death before the age of 35 years?___ ☐ Unknown

OVER →

Student Medical History

Does your child currently take any medications? ☐Yes ☐No
Please list any medications with current dose (how much and how often):

_____

_____

Emergency medication kept at school? ☐ Yes ☐No _____
Is your child allergic to any medications? ☐ Yes ☐ No _____
Is your child allergic to environmental factors (bees, latex, nuts, food, etc.)? ☐ Yes ☐ No
Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.):

Name of Allergen *Type of Reaction*

_____ _____

_____ _____

Who is your child's dentist? _____

Consent

Please read carefully, COMPLETE FORM, SIGN, and DATE. Student should return this form to their homeroom teacher. Please notify Healthy Kids Clinic if there are any health changes or a change in guardianship. Consent will not expire until your child leaves the District or the Healthy Kids Clinic is notified in writing that you wish to revoke such.

I give my consent for _____ _____ _____
Student's Full Name ***Birth Date*** ***Social Security Number***

to receive the following services at Cumberland Family Medical Center, Inc. School Based Health Centers (PLEASE INITIAL):

_____***School Nurse Services Only*** (Including illness assessment, emergency medication administration, OTC medications, basic triage) completed by an RN, LPN, or MA. The following over the counter medications are available to your child by the school nurse if the symptoms deem necessary:

Calamine	Antacid (Tums)	Antibiotic Ointment (Polysporin)
Hydrocortisone cream	Benadryl	Claritin (for allergies)
Orajel	Cough Drops	Sunscreen
Tylenol	Aloe Vera	Icy Hot (high school only)
Motrin/Advil	Anti-itch Spray	Guaifenesin

****If you do NOT consent for your child to have any of the medications listed, please draw a line through the medication and initial beside it.***

_____***Nurse Practitioner/Physician Assistant/Telehealth Services If you would like to be contacted prior to the exam, please initial _____.***
(NP/PA/Telehealth services for acute illness, wellness exams, CLIA waived testing, sports physicals, etc.)

_____***Well Child Exam*** (Yearly physical to assess height, weight, vision, hearing, anticipatory guidance, etc.). ***If you would like to be contacted prior to the exam, please initial _____. Date of last wellness exam*** _____

_____***Behavior Health Crisis*** (In the event of a crisis, a Healthy Kids Clinic behavioral health professional may be asked to provide an assessment or consulation for your student.) Parent will be contacted.

_____***No Services at this time*** (this includes school nurse services)

I give consent to Cumberland Family Medical Center, Inc. School Based Health Center (hereinafter CFMC SBHC) staff to render the needed treatment, perform the needed test, and document attendance, immunizations, and review/document on KYIR or Infinite Campus any other information, if applicable, that will assist the staff in providing care for the patient/myself. I understand that CFMC shall provide a copy of its Notice of Privacy and HIPAA Practices upon my request, which is also available at www.cumberlandfamilymedical.com. ***I authorize CFMC to release any information required for payment of insurance claims and authorize my insurance, Medicare or Medicaid to be paid directly to the clinic. I understand I am responsible for any co-payments and/or deductibles incurred from my insurance plan.*** *If this cannot be done, I agree to make arrangements with the clinic. I authorize CFMC SBHC staff to release and receive medical information from the patient/my primary care providers and specialists. I give consent for this protected health information to be shared with school district staff who may need to provide care in an emergency situation. Furthermore, I give consent for CFMC SBHC staff, Board of Education staff, and the patient/my primary care provider, to communicate and share medical and psychological conditions on an as needed basis with the understanding that all information will be treated in a confidential manner.*

SIGNATURE REQUIRED

_____ _____ _____
Parent/Guardian Signature ***Print Name*** ***Date***

_____ _____ _____
Patient Signature (if 18 years or older) ***Print Name*** ***Date***