HEALTHY KIDS CLINIC

Healthy Kids Clinic Registration Form
Students

District: _____
School: _____
Grade: _____

PATIENT INFORMATION

Please complete the following information about your child:

Patient's Last Name:	First:	Middle:	Date of Birth:	Social Security Number:

Mother's First and Last Name:	Father's First and Last Name:	Who is legal guardian? (If foster child, list social worker name and phone number below)	Child's Last Name at Birth:	Sex: ☐ M ☐ F

Street Address:	P.O. Box:	
City:	State:	ZIP Code:

Guardian Home Phone Number:	Guardian Cell Phone Number:	Employer Phone Number:

Emergency Contact Name & Phone Number (Other Than Guardian):
Additional Emergency Contact Name & Phone Number (Other Than Guardian):

What pharmacy do you use? City: Phone:

Language: ☐ English ☐ Spanish ☐ Other: _____

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

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

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

Who is your child's primary care physician?

MEDICAL INSURANCE INFORMATION

If your child has a Medicaid card, KCHIP card, or Private Insurance, please complete the information below for your insurance to be processed in the event your student is seen by Healthy Kids Clinic.

Insurance Company Name:	Insurance Company Address:	Insurance Company Phone Number:

ID Number:	Group Number:

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

Address of policy holder, if different than patient:

☐ Check this box if you do not have medical insurance, and you will be contacted by our Patient Financial Services department if seen by the provider.

Health History

Healthy Kids Clinic • PO Box 2399
Russell Springs, KY 42642
Toll Free: (844) 435-0900

Family History

Please label below with C for child, M for mother, F for father, S for sibling, G for grandparent, and P for patient (self)
Do you have a family history of:

___No Problems
___Asthma
___Diabetes
___Heart Murmur/Congenital Heart Defect
___High Blood Pressure
___Anemia
___Thyroid Problems
___Epilepsy/Seizures
___Gastric Reflux
___Frequent Ear Infections
___Urinary Problems
___Tonsils/Adenoids Removed
___Ear Tubes
___Hernia
___Frequent Sore Throats
___Eye Problems/Wear Glasses
___Kidney Disease
___ADHD
___Depression/Anxiety/Mood Disorder
___Development Learning Problems
___HIV/AIDS
___Hepatitis A
___Hepatitis B
___Hepatitis C
___Other (please list): _____

Have you had any of the following diseases:
___Chickenpox
___Meningitis
___RSV

Medications

Do you currently take any medications? ___Yes ___No
Please list any medications with current dose (how much and how often): _____

Allergies

Are you allergic to environmental factors (bees, latex, nuts, food, etc.) or medications? ___Yes ___No
Please list any allergies with type of reaction (rash, lips swelling, can't breathe, etc.):

Name of Allergen	*Type of Reaction*

Is there any additional information you would like us to know about you? _____

Medical Release of Information

As the patient you have the right to give access of you medical records to whomever you choose. Please list below anyone you would like to have access to your medical records.

Name	Relationship to Patient	Phone Number

I give consent for Cumberland Family Medical Center, Inc. and its providers and staff to render the needed treatment and/or test the patient. I understand that Cumberland Family Medical Center, Inc. shall provide a copy of its Notice of Privacy Practices and HIPPA policy upon my request, which is also available at www.cumberlandfamilymedical.com.

SIGNATURE REQUIRED

Signature	*Print Name*	*Date*

HEALTHY KIDS CLINIC

Administration of Medication Form

Dear Parent/Guardian:

If your child requires medication please try to schedule it before or after school hours. If the medication is to be given during school hours, we must have this form completed and signed by you and your child's physician. Your doctor may fax this for to the school office. The duration of this form is for one (1) school year only

SCHOOL YEAR _____

NAME: _____ **DATE OF BIRTH:** _____

GRADE: _____ **ALLERGIES:** _____

TO BE COMPLETED BY PHYSICIAN OR AUTHORIZIED PROVIDER

1. **Medication:** _____ **Dose:** _____
Directions: _____
Administration Time(s): _____ **Route:** _____
Diagnosis: _____ **Duration Start:** _____ **Stop:** _____

2. **Medication:** _____ **Dose:** _____
Directions: _____
Administration Time(s): _____ **Route:** _____
Diagnosis: _____ **Duration Start:** _____ **Stop:** _____

3. **Medication:** _____ **Dose:** _____
Directions: _____
Administration Time(s): _____ **Route:** _____
Diagnosis: _____ **Duration Start:** _____ **Stop:** _____

***For Inhaler, Epipen, FDA approved seizure rescue medication, and/or Glucagon, the student has received training to carry the inhaler or emergency medication and **MAY CARRY** and **SELF-ADMINISTER** this medication.

☐ YES ☐ NO

***For overnight field trips, the student has received training and **MAY CARRY** and **SELF-ADMINISTER** the medication/s listed above.

☐ YES ☐ NO

I give permission for the administration of this medication/s by trained school personnel according to standard school policy and expressly waive any liability on behalf of the school as a result of administration of the above medication/s. School officials may need to contact the ordering physician if additional information is needed. I hereby authorize release of any needed information from the ordering physician regarding this medication. Student may self-administer the above medication/s with school trained personnel supervision while on a field trip. In case of field trips or school related functions, slight adaptations to the time the medication is administered may also be necessary.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Phone	Date
_____	_____	_____
Physician's Signature	Physician's Phone	Date
_____	_____	_____
Print Physician's Name	Physician's Address	FAX Number