



Patient Label

### School-Based Wellness Center-Registration & Health History

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  Native Hawaiian/Pacific Islander  
 Asian  White/Caucasian  
 Black/African American

**Name of Student's Medical Provider (Doctor):** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**NO PHYSICIAN OR MEDICAL PROVIDER**

**Name of parent/legal guardian:** \_\_\_\_\_ Relationship to child: \_\_\_\_\_

**Parent/guardian Phone:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ **Email:** \_\_\_\_\_

### 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#** \_\_\_\_\_

Barcode



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**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  and indicate which blood relative (i.e. parents, grandparents, siblings) have had the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood Clots in legs/lungs	<input type="checkbox"/> Cancer
<input type="checkbox"/> Obesity	<input type="checkbox"/> Other:	

### 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.

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Asthma
<input type="checkbox"/> Cancer (type):	<input type="checkbox"/> Chicken Pox -year:	<input type="checkbox"/> Cholesterol (high)	<input type="checkbox"/> Clotting Disorder
<input type="checkbox"/> Concussion	<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Eating Disorder
<input type="checkbox"/> Headache-Migraine	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Overweight/Obesity	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Rashes/Skin problem	<input type="checkbox"/> Seizures
<input type="checkbox"/> Self-injurious Behavior	<input type="checkbox"/> Physical Limitations	<input type="checkbox"/> Suicide Attempts	<input type="checkbox"/> Smokes/Chew Tobacco
<input type="checkbox"/> Trauma/Violence	<input type="checkbox"/> Ulcer/Reflux	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Other:

Explanation of CURRENT illness or problems: \_\_\_\_\_

#### List all past surgeries:

Type of Surgery	Date
	Date / /
	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/LegalGuardian: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Barcode