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

Healthy Kids Clinic
A Part of Cumberland Family Medical Center, Inc.
PO Box 2399 · Russell Springs, KY 42642
Toll Free: 844.435.0900
www.healthykidsclinics.com

Dear Parent/Guardian:

Thank you for entrusting the Healthy Kids Clinic in providing school health services for your student this year. The Healthy Kids Clinic school health program offers many types of services. You as the guardian can choose what services you want for your student. Below are explanations of the forms to be filled out and returned to school.

- Healthy Kids Clinic Registration Form: This is your student's school health registration form for the 2024-2025 school year. It is very important that you complete and sign this form **even if you only want your child to see the school nurse**. On the consent portion of this form, you can choose which services you want for your student. Please make sure to include the most recent demographics and health history. *If you child takes a daily medication or has a chronic care condition the school nurse will contact you with further details on other documentation that is needed.

If you have questions regarding school health, please contact your school nurse or our Healthy Kids Clinic administrative office at 1-844-435-0900. We look forward to working with you this school year!

Sincerely,

The Healthy Kids Clinic

HEALTHY KIDS CLINIC

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Healthy Kids Clinic Registration Form

Students

District: _____

School: _____

Grade/Teacher: _____

2024-2025 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: City: State: Zip:

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

Emergency Contact Name & Phone (Other Than Guardian):

Is your child allergic to any medications? ☐ Yes ☐ No _____

What pharmacy do you use? City: Phone:

Language: ☐ English ☐ Spanish ☐ Other: Race:

Ethnicity: ☐ Non-Hispanic or Latino ☐ Hispanic or Latino ☐ Other (write in ethnicity): _____

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 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 does (how much and how often):

_____

_____

Emergency medication kept at school? ☐ 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 Kid 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** (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
	Vaseline	Artificial Tears/Eye Wash

***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**
(NP/PA for acute illness, wellness exams, CLIA waived testing, sports physicals, etc.)

_____ **Telehealth Services**
(NP/PA for acute illness, wellness exams, CLIA waived testing, etc.)

_____ **Well Child Exam** (yearly physical/sports 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 physical: _____
If you routinely go to a pediatric office for a yearly check up, please do not initial this line.

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, document 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 of older)	**Print Name**	**Date**