



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 Transgender Male Transgender Female Decline to Answer

Ethnicity: Hispanic or Latino Not Hispanic or Latino **Student's Preferred Language:** English Spanish Other: _____

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

In case of EMERGENCY contact: _____
Name Relationship to student Phone Number

Mother's Name: _____ **Phone:** (Home) _____ (Cell) _____

Email address: _____ **Employer Name:** _____

Father's Name: _____ **Phone:** (Home) _____ (Cell) _____

Email address: _____ **Employer Name:** _____

Guardian's Name: _____ **Phone:** (Home) _____ (Cell) _____

Email address: _____ **Employer Name:** _____

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

Address: _____ **Phone:** _____

NO PHYSICIAN OR MEDICAL PROVIDER

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 |
|-----------------|------|
| | |
| | |

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

If yes, what are your concerns? _____

Is your student 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: _____

Barcode