



# Healthy Kids Clinic Registration Form Students

District: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Grade/Teacher: \_\_\_\_\_  
 2025-2026 School Year

## PATIENT INFORMATION

Please complete the following information about your child

Child's Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_  
 Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: \_\_\_\_\_  
 First & Last Name of ALL Parents/Guardians: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Guardian #1 Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relation: \_\_\_\_\_  
 Guardian #2 Name: \_\_\_\_\_ Phone Number: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relation: \_\_\_\_\_  
 Emergency Contact Name, Phone, & Relation (Other Than Guardian): \_\_\_\_\_  
 Language:  English  Spanish  Other: \_\_\_\_\_ Race: \_\_\_\_\_  
 Ethnicity:  Non-Hispanic or Latino  Hispanic or Latino  Other (write in ethnicity): \_\_\_\_\_  
 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  
 What pharmacy do you use? \_\_\_\_\_ City: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_-\_\_\_\_  
 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? \_\_\_\_\_

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Policy Holder Social Security #: \_\_\_\_-\_\_\_\_-\_\_\_\_ 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

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

### 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.)

- |  |   |  |  |   |
|--|---|--|--|---|
| <input type="checkbox"/> Anxiety_____  | <input type="checkbox"/> Asthma_____            | <input type="checkbox"/> Congenital Heart Defect _____ | <input type="checkbox"/> Cardiomyopathy_____       | <input type="checkbox"/> Depression_____        |
| <input type="checkbox"/> Diabetes Type I _____   | <input type="checkbox"/> Diabetes Type II _____ | <input type="checkbox"/> Epilepsy/Seizures _____       | <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Hypothyroidism _____  | <input type="checkbox"/> Heart Murmur _____     | <input type="checkbox"/> Pacemaker _____               | <input type="checkbox"/> Sickle Cell Anemia _____  |   |
| <input type="checkbox"/> Unexpected or unexplained death before the age of 35 years? _____ | <input type="checkbox"/> Unknown _____          |  |  |   |

**Please complete back of form.**

## STUDENT MEDICAL HISTORY

Does your child currently take any medications?  Yes  No

Please list any medications with current doses (how much and how often):

Is your child allergic to any medications?  Yes  No

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.

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

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](http://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