



Healthy Kids Clinic
Registration Form
Staff

District:
School:
2025-2026 School Year

PATIENT INFORMATION

Please complete the following information

Patient's Last Name: First: Middle:
Date of Birth: Social Security #: Sex Assigned at Birth:
Street Address: City: State: Zip:
Emergency Contact Name, Phone, & Relation:
Language: Race:
Ethnicity:
Who is your primary care physician? Phone: Fax:
Would you like for your visit notes to be sent to your primary care physician?
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

Past Surgical History (with date included)

- 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

- 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 Type 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

Please complete back of form.

STUDENT MEDICAL HISTORY

Do you currently take any medications? Yes No
 Please list any medications with current doses (how much and how often):

Are you allergic to any medications? Yes No _____

Emergency medication kept at school? Yes No

Are you 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.): _____

<i>Name of Allergen</i>	<i>Type of Reaction</i>
_____	_____
_____	_____
_____	_____

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 your medical records to whomever you choose. Please list below anyone you would like to have access to your medical records.

<i>Name</i>	<i>Relationship to Patient</i>	<i>Phone Number</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

_____	_____	_____
Signature	Print Name	Date