KU SCHOOL OF MEDICINE WICHITA MEDICAL PRACTICE ASSOCIATION
The University of Kansas

CHILD AND ADOLESCENT PATIENT DEMOGRAPHIC FORM

PLEASE PRINT CLEARLY

PATIENT INFORMATION

Patient's Full Legal Name

Last:	First:	Middle Initial:

Preferred Name/Nickname:	Social Security Number: - -	Date of Birth: / /	Sex: ☐ Male ☐ Female

Race: ☐ African American/Black ☐ Asian ☐ White ☐ Middle Eastern or North African ☐ Native Hawaiian or Pacific Islander ☐ American Indian or Alaska Native ☐ Other _____

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Street Address / PO Box:	Lot / Apt #:	City:	State:	Zip Code:

Primary Phone #: ( )	Cell/Mobile? ☐ Yes ☐ No	Secondary Phone #: ( )	Cell/Mobile? ☐ Yes ☐ No

Email Address:	Preferred Language:

How were you referred to or how did you discover KU Wichita MPA Clinics?

School Name:	Current Grade:

CURRENT HEALTHCARE PROVIDER INFORMATION

Primary Care Physician/Provider:	Referring Physician/Provider:

Preferred Hospital:	Preferred Pharmacy:

BILLING/INSURANCE INFORMATION

Primary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

Secondary Health Insurance Company:	Policy Holder Full Name:	Policy Holder Date of Birth:

PATIENT'S PARENT/GUARDIAN INFORMATION

Parent #1 Name:	Address:	Phone #: ( )

Parent #2 Name:	Address:	Phone #: ( )

Guardian Name:	Relationship:	Address:	Phone #: ( )

CUSTODY ARRANGEMENTS - *Please Provide Copies of Any Court Orders or Other Legal Documentation*

Are there custody arrangements, either current or pending, between any parties? ☐ Yes ☐ No

Legal Guardian ☐ Yes ☐ No	**Name:**	**Phone #:**
DCF Involvement ☐ Yes ☐ No	**Name:**	**Phone #:**
Juvenile Justice Involvement ☐ Yes ☐ No	**Name:**	**Phone #:**

HIPAA CONTACTS - AUTHORIZED REPRESENTATIVES

By listing contacts below, you authorize our office to communicate with them regarding your health, treatment, and billing under HIPAA. ☐ No HIPAA Contacts

Name:	Relationship:	Phone #:

Name:	Relationship:	Phone #:

EMERGENCY CONTACTS

Someone we may contact in an emergency or if you're unreachable, but are not authorized to receive your medical information. ☐ No Emergency Contacts

Primary Emergency Contact Full Name:	Relationship:	Phone #:	City & State:

Signature of Patient, Responsible Party, or Authorized Legal Representative

Date

Printed Name of Patient, Responsible Party, or Authorized Legal Representative

Relationship to Patient

KU Wichita USD 261 Haysville / School-Based Health Care

PEDIATRIC PATIENT MEDICAL HISTORY FORM

(please complete both sides – attach additional form if needed)

Date	Child's Name		DOB

Primary Care Physician (PCP)	PCP Phone Number	Date of Last Well Child Exam

Mother's Full Name	Father's Full Name

Custodial provider (If different from above)	Relationship to Patient

Does the child have an eye doctor? No Yes (if yes, please provide name and date of last exam)	Does the child have a dentist? No Yes (if yes, please provide name and date of last appointment)

Preferred Pharmacy Name, Address, phone number

With whom does the child live (list all household members and their relationship to child):

Does anyone smoke in or outside the home? No Yes

Is this child currently or has he/she ever been in foster care? No Yes, currently (specify age child entered foster care _____)
Yes, in the past (specify ages in foster care _____)

Birth and Development History

Birth weight_____
Pregnancy #_____
Mom's age at delivery _____
Type of birth:
Vaginal Cesarean (reason _____)
Term Premature (how many weeks early _____)

Did mom have any illnesses/problems during pregnancy?
No Yes (if yes, please explain_____)

Before mom knew she was pregnant or anytime during her pregnancy, did she use:
Cigarettes (how many per day? _____)
Alcohol (drinks per week? _____)
Any other substance/drug, prescribed or not, to get "high" (type and how often? _____)

Did your child have any problems during or after birth?
No Yes (if yes, please explain _____)

Did your child have any developmental delays? No Yes
(if yes, please explain _____)

Does your child receive any services at school for a developmental, behavioral, or medical diagnosis such as a 504 or Individualized Education Plan (IEP)? No Yes
(if yes, please explain _____)

Does your child see any medical specialists? No Yes
(if yes, please explain _____)

Medical History

List current medications your child is taking (attach additional page if necessary):

Medication Name	Dosage	Time of Day Taken	Prescribers Name

List any allergies your child has to foods or medications: _____

Has your child received all the recommended vaccinations recommended for their age? Yes No (if no, why? _____)

Medical History (Continued from previous page)

List any surgeries your child has had and the year they had the surgery: _____

_____

List any medical illnesses your child has (asthma, diabetes, seizures, migraines, etc.): _____

_____

List any mental health diagnoses your child has and who is providing treatment (therapists, physicians, APRNs, counselors, etc.):

_____

_____

List any surgeries or overnight hospitalizations your child has had: _____

_____

Family Medical History (Parents, Siblings, Grandparents, Aunts and Uncles)

Have Any Family Members Had the Following:

Alcohol/Drug Abuse	□ Y	□ N	Details:
Allergies	□ Y	□ N	Details:
Asthma	□ Y	□ N	Details:
Birth Defects	□ Y	□ N	Details:
Blood Disorders	□ Y	□ N	Details:
Bone Disorders	□ Y	□ N	Details:
Cancer	□ Y	□ N	Details:
Diabetes	□ Y	□ N	Details:
Endocrine Disease	□ Y	□ N	Details:
Ear/Nose/Throat Disorders	□ Y	□ N	Details:
Eye Disorders	□ Y	□ N	Details:
Gastrointestinal Disorders	□ Y	□ N	Details:
Heart Disease	□ Y	□ N	Details:
High Blood Pressure	□ Y	□ N	Details:
High Cholesterol	□ Y	□ N	Details:
Immune Disorders	□ Y	□ N	Details:
Joint Problems	□ Y	□ N	Details:
Kidney Disease	□ Y	□ N	Details:
Liver Disease	□ Y	□ N	Details:
Lung Disease	□ Y	□ N	Details:
Migraine Headaches	□ Y	□ N	Details:
Metabolic Disorders	□ Y	□ N	Details:
Obesity	□ Y	□ N	Details:
Seizure Disorders	□ Y	□ N	Details:
Skin Disorders	□ Y	□ N	Details:
Stroke History	□ Y	□ N	Details:
Thyroid Disorders	□ Y	□ N	Details:
Mental Health History	□ Y	□ N	Details:
Other Medical History	□ Y	□ N	Details:
Other Medical History	□ Y	□ N	Details:

Please list any other pertinent information to your child's medical history for the medical provider: _____

_____

_____

_____

_____

_____

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
The University of Kansas

CONSENT TO COMMUNICATE ELECTRONICALLY

What types of communication could be sent to me?

University of Kansas School of Medicine – Wichita Medical Practice Association "UKSM-W MPA" may send messages regarding your care, such as:

- Appointment reminders and scheduling updates
- Billing and payment notices
- Health-related information or education
- Feedback requests about your visit or services

How might I receive communications?

You may receive communications through one or more of the following:

- Email Notifications
- Text message (SMS)
- Phone or Voice over Internet Protocol (VoIP).

Some messages may be sent using automated dialing systems or include prerecorded/artificial voice.

Will the communications be secure?

Most emails will be encrypted. However, some emails or text messages containing limited personal information may not be encrypted and could pose a security risk. While the likelihood of interception is low, unencrypted messages may be accessed by unauthorized parties. By consenting to electronic communication, you acknowledge and accept this risk. UKSM-W MPA will take reasonable steps to protect your information but cannot guarantee complete security of unencrypted messages.

Are there any costs to me?

Standard text messaging or data rates may apply depending on your mobile plan. Please contact your wireless carrier for details.

What if I do not want to receive these communications?

You are not required to consent to receive electronic communications. You may opt out at any time by:

- Replying "STOP" to any text message
- Clicking "Unsubscribe" on any email
- Contacting your UKSM-W MPA clinic directly

Your preferences will remain in effect unless you update them or give a different type of consent for a specific clinic service or communication platform (such as a patient portal).

Consent Options (Select One):

☐ **I ACCEPT** – I consent to receive electronic communications from UKSM-W Medical Practice Association.

☐ **I DECLINE** – I do not wish to receive electronic communications at this time.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL OF MEDICINE WICHITA
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ACKNOWLEDGEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

PATIENT RIGHTS

As a patient of UKSM-W Medical Practice Association (MPA), you have the right:

- To be treated with respect, dignity, consideration, and compassion.
- To receive services free of discrimination on the basis of race, color, sex/gender, ethnicity, national origin, religion, age, class, sexual orientation, physical or mental ability.
- To participate in creating a care plan and in making decisions that affects your care.
- To be informed about services and options available to you, including the cost.
- To have your personal information and medical records be treated confidentially.
- To communicate in a language you can understand.
- To consent or refuse to participate in any proposed research study without retribution or difference in the quality of your care.
- To file a grievance about services you are receiving or denial of services.
- To not be subjected to physical, sexual, verbal and/or emotional abuse or threats.

PATIENT RESPONSIBILITIES

As a patient of UKSM-W MPA, you have the responsibility:

- To treat other patients and staff of this clinic with respect and courtesy.
- To protect the confidentiality of other patients you encounter in this clinic.
- To participate as much as you are able in creating a care plan, asking questions until you fully understand your care plan, and participating in decision-making that affects your care.
- To let your physician and provider/care team know any concerns you may have about your care plan or changes in your needs.
- To make and keep appointments to the best of your ability, or if possible, to call to cancel or change an appointment time.
- To keep clinic informed of changes in your personal information, including address, phone number, or insurance to ensure timely processing of bills and to promptly meet your financial obligations.
- To provide accurate information to your physician and provider/care team about your symptoms, past illnesses, hospitalizations, medications, and behaviors that may affect your health.
- To follow your care plan and tell physicians and nurses about any obstacles you may encounter in continuing your care plan.
- To consent to a blood test if any healthcare worker should come in contact with your blood.
- To follow clinic rules, such as our no-smoking policy and clinic expectations for patient and visitor behavior, which includes refraining from the use of profanity; verbally abusive, offensive, and/or sexually suggestive language; threatening statements or any act or threat of inappropriate behavior.

I acknowledge that I have reviewed and understand these rights and responsibilities, and I understand that my signature below means that I am agreeing to do my part to respect the clinic's policies and to help create a safe, healing environment. I understand that failure to comply with the terms of this Agreement may prevent me from continuing to receive care from the clinic.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

PROXY CONSENT TO TREAT MINORS

Purpose: This form may be used to allow an adult (age 18 or older) other than a parent to serve as a **proxy** decision maker for medical care and services at KU Wichita Medical Practice Association locations.

Authorization I hereby appoint the following adult(s) as a decision maker to consent to and authorize routine health care treatment and services for my child listed below.

Proxy Name *(Print)*	**Relationship to Child**
Proxy Name *(Print)*	**Relationship to Child**
Proxy Name *(Print)*	**Relationship to Child**

I understand medical care treatment and services may include, but are not limited to; medical evaluation, physical exam, immunizations, x-rays, and lab work. I hereby empower and grant the decisions maker(s) appointed above, permission to consent to and authorize routine medical care as may be deemed necessary or advisable in the diagnosis and treatment of the minor child listed below and to receive protected healthy information (PHI) directly relevant to, and for purposes of, his or her involvement in this care or payment related to this care. (Complete a separate form for each child.)

Child's Name:_____ **DOB:** _____

Parent's/Guardian Name:	Parent's/Guardian Name:
Daytime Phone:	Daytime Phone:
Evening Phone:	Evening Phone:
Cell Phone:	Cell Phone:

I understand there is no obligation to contact me if the decision maker consents to the care. The individual appointed as decision maker herein is permitted to make decisions or consent to the care in my absence. I also agree to accept financial responsibility of all care and services delivered pursuant to the authorization. This authorization is valid for one (1) year following the date signed below unless withdrawn in writing to KU Wichita Medical Practice Association (only one parent's signature is required).

_____ _____

Signature of Parent or Legal Guardian **Signature of Parent or Legal Guardian**

_____ _____

Date **Date**

SCHOOL OF MEDICINE WICHITA
MEDICAL PRACTICE ASSOCIATION
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SCHOOL-BASED HEALTH CARE
PARENTAL CONSENT FORM TO RECEIVE HEALTH CARE SERVICES

HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of KU Wichita Pediatric / School-Based Health Care and understand this may include learners working under the licensure of the supervising physician, APRN, or PA-C. I understand that confidentiality between the student and the physician and provider will be ensured in specific service areas in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. Health Clinic services may include, but are not limited to:

1. Screening for vision, hearing, asthma, obesity, scoliosis, Tuberculosis and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, sports, working papers, and new admissions.
3. Medically prescribed laboratory tests such as for infections, anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and smoking abuse, as well as education on abstinence and prevention of pregnancy, sexually transmitted infections, and HIV, as age appropriate.
7. Referrals for service not provided at the health center.
8. Screening questionnaires.

INFORMED CONSENT FOR TELEHEATH SERVICES

I authorize the use of telehealth technology for remote evaluations and treatment.

- I may be seen via video or audio-only communication, depending on clinical need and technology availability.
- I understand that technical issues may delay care.
- Privacy laws, including HIPAA, apply to all telehealth services.
- My physician and provider will not record the session without my consent, and my information will not be shared with third parties without authorization.
- I may withdraw this consent at any time without affecting my right to future care.
- I understand my insurance may not fully cover telehealth visits and I may be responsible for uncovered charges.
- Telehealth may involve the transmission of my medical information across state or regional networks using secure platforms with encryption and privacy protections.

USE OF AI DICTATION TECHNOLOGY

To support accurate and efficient documentation of your care, our clinic uses AI-powered dictation technology to transcribe verbal information into text for inclusion in your medical record. By signing this consent to treatment, you acknowledge and understand the following:

- AI may be used to transcribe verbal information into text for efficiency and accuracy in my medical record.
- Audio input used for AI transcription is deleted within 7 days. AI is not used to make clinical decisions.
- My physician and provider will personally review and confirm all AI-dictated content before it becomes part of my official medical record.
- Security protocols including encryption and access control protect the confidentiality of my information.
- I may request access to or corrections of my records at any time.

YOUR RIGHT TO OPT-OUT OF AI DICTATION TECHNOLOGY

You have the right to decline the use of AI dictation during your visit. If you choose to opt out:

- Please notify your physician and provider or clinic staff before your appointment begins.
- Your physician and provider will document your visit using traditional methods.

VALUABLES

I understand that UKSM-W Medical Practice Association is not responsible for any personal valuables that are lost, stolen, or damaged while I am on clinic premises. I am advised not to bring valuables to appointments.

DISCLOSURE OF HEALTH HISTORY

I have reviewed the health history form with my student and completed their health history.

PARENTAL CONSENT FOR HEALTH CENTER SERVICES

I have read and understand the services listed above (Health Center Services) and my signature provides consent for my child to receive services provided by the KU Wichita Pediatric / School-Based Health Care. Parental consent is not required for students who are 18 years or older or for students who are legally emancipated. NOTE: Per state law, statute 38-123b: “Notwithstanding any other provision of the law, any minor sixteen (16) years of age or over, where no parent or guardian is immediately available, may give consent to the performance and furnishing of hospital, medical or surgical treatment or procedures and such consent shall not be subject to disaffirmance because of minority. The consent of a parent or guardian of such a minor shall not be necessary in order to authorize the proposed hospital, medical or surgical treatment or procedures.”

Patient Name *(Print)* _____ **Date of Birth (MM/DD/YYYY)** _____

Signature of Parent/Guardian (or student if 18 years or older or otherwise permitted by law) _____ **Date** _____

SCHOOL-BASED HEALTH CARE
AUTHORIZATION FOR BILLING AND HEALTH INFORMATION RELEASE

CONSENT TO BILL INSURANCE AND RESPONSIBLE PARTY

I understand that the health clinic needs to cover its expenses and therefore bills for services rendered. This includes billing third parties such as any applicable health insurer. I further understand that that I, as the patient or the responsible party for the patient, will be billed directly for health services provided by KU Wichita Pediatric / School-Based Health Care that are not covered by my insurer.

I agree to pay and assume all responsibility for medical and hospital expenses and any emergency services incurred not covered by my insurance. UKSM Wichita Medical Practice Association will produce a "Good Faith Estimate" if requested by the self-pay patient/guardian. Good Faith Estimates provide a quote for the cost of treatment prior to services being performed. Patient may authorize the physician and provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act can be provided to the patient upon request.

Patient statements will be generated after UKSM Wichita Medical Practice Association has received payment from your insurance company. Methods of communication, including but not limited to, email and text messages, may be used to contact a patient regarding their balance. Patients are automatically opted-in for voice messages, text messages, and email reminders regarding their balance. To opt-out, please provide verbal or written notice to a UKSM Wichita Medical Practice Association receptionist or the business office. If I have concerns regarding billing, I understand that I should contact KU Wichita Medical Practice Association at (316) 293-3429 and not KU Wichita Pediatric / School-Based Health Care or the school where health services were provided.

CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes release of medical information. This information may be shared for:
(1) the patient's treatment, including disclosure to school personnel involved in a student's health care—including but not limited to the school nurse, health aide, social worker, counselor, and mental health care provider on campus—to the extent required to provide quality, comprehensive medical care. For adult patients health information will not be disclosed to school personnel unless specifically authorized by the patient or permitted by law; and
(2) for billing and payment purposes.

I acknowledge I have received a copy of KU Wichita Medical Practice Association's Notice of Privacy Practices and I understand that I have a right to review these privacy practices before signing this consent form. I understand that KU Wichita Medical Practice Association may change its privacy practices in the future, and that I may request a copy of the new privacy practices at any time. I also understand that I can contact KU Wichita Medical Practice Association's Privacy Officer with any questions I may have about the Notice of Privacy Practices.

In addition to the other uses and disclosures described in this document, I consent to the use and disclosure of the patient's health information for the purposes described in the Notice of Privacy Practices. In addition to the above, information about the patient may be shared as part of reporting child or adult abuse and/or neglect or other exceptions included in Kansas law.

CONSENT FOR RELEASE OF HEALTH INFORMATION

I have read and understand the consent for release of health information. My signature indicates my consent to release medical information as specified.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____

SCHOOL-BASED HEALTH CARE
ACKNOWLEDGEMENT OF POLICIES

University of Kansas School of Medicine – Wichita Medical Practice Association ("MPA") has made updates to the following policies:

- **Notice of Privacy Practices** - *Revised December 2025*
- **Notice of Non-Discrimination** - *Revised December 2025*

Printed copies of each policy are available upon request at the front desk. Please sign below to acknowledge that you have been informed of these policy updates and have had the opportunity to review or request a copy.

Patient Name ***(Print)*** _____ **Date of Birth (MM/DD/YYYY)** _____

Patient Signature (student if 18 years or older or otherwise permitted by law) _____ **Date** _____

If the patient lacks capacity or is a minor, signature of the parent, guardian, or authorized legal representative is required:

Representative Name ***(Print)*** _____ **Relationship/Authority to Sign** _____

Representative Signature _____ **Date** _____