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

Healthy Kids Clinic Registration Form

Students

District:_____
School:_____
Grade/Teacher:_____
2026-2027 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

☐ **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

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

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)	***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.**
Hydrocortisone Cream	Benadryl	Claritin/Zyrtec (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	

_____ **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. ***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**