

### Patient Information

First Name _____	Last Name _____
Date of Birth _____	Social Security _____
Primary Language _____	Grade _____
Address _____	City, State _____
Zip Code _____	Name of School _____
Gender Identity <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male (Female to Male) <input type="checkbox"/> Transgender Female (Male to Female) <input type="checkbox"/> Other <input type="checkbox"/> Decline to Answer	
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Decline to Answer Race (Check off all that apply) <input type="checkbox"/> Black/African American <input type="checkbox"/> Caucasian (White) <input type="checkbox"/> American Indian/Alaska <input type="checkbox"/> Asian <input type="checkbox"/> Native American Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Multiple Races <input type="checkbox"/> Decline to Answer	

### Parent/Guardian/Emergency Contact Information

First Name _____	Last Name _____
Date of Birth _____	Social Security Number _____
Home Phone _____	Cell Phone _____
Parent/Guardian Email Address _____	
Emergency Contact Name _____	Relationship _____
Home Phone _____	Cell Phone _____
Pharmacy _____	Pharmacy Address _____

### Insurance Information: Please provide the following medical and dental insurance information noted on the back of your insurance/medicaid card.

Primary Insurance _____	Policy Holder Name _____
Policy Number _____	Policy Holder Date of Birth _____
Primacy Insurance Contact Number _____	
Does the patient have Dental Insurance? _____	Yes/No _____
Dental Insurance _____	Policy Holder Name _____
Policy Number _____	Policy Holder Date of Birth _____
Dental Insurance Contact Number _____	

### Medical History/Allergies

Does the patient have any medical conditions?	Yes	No
Does the patient take any medication? (Including Inhalers)	Yes	No
Does the patient have any allergies to food, medications, or local anesthetics?	Yes	No
Does the patient carry an EPI-PEN at school in case of an allergic reaction?	Yes	No
Has the patient had any serious injuries?	Yes	No
Does the patient have a birth or heart defect?	Yes	No
Does the patient have history of heart problems or surgery?	Yes	No
Has the patient ever been hospitalized overnight?	Yes	No
Has the patient had any surgery in the past?	Yes	No
Has the patient had any shunts placed or have an indwelling catheter?	Yes	No
Does the patient smoke or chew tobacco?	Yes	No

If answered yes to any of the above, please comment below

Please list any concerns you have regarding your child's Physical or Mental Health

### Dental History

Any pain or problems with teeth?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Any bleeding when brushing or flossing	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Had a dental cleaning within the last 6 months?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Is premedication with antibiotics needed prior to dental procedures?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
If answered yes to any of the above please comment				

### Family History

		Illness	Relative	Explain
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Diabetes, Endocrine Disorder (Thyroid)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Cancer
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Heart Problem, Stroke
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	High Blood Pressure
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Blood Disorder including Anemia
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Clotting Disorders
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Respiratory Problems including Asthma
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Mental Illness (i.e. Depression)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Alcohol/Drug Problems
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Infections (TB/HIV/AIDS)
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Death Under the age of 50
<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	Other

### Primary Care Provider

Primary Care Provider	
Name _____	Address _____
Phone _____	Fax _____

### Parent/Guardian Consent & Signature

I give my child permission to obtain ON-SITE MEDICAL SERVICES.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I give my child permission to obtain ON-SITE/MOBILE DENTAL SERVICES	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I give my child permission to obtain ON-SITE BEHAVIORAL HEALTH SERVICES	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<p>I, the parent/guardian of the student, give consent for my child to receive the services checked above at the school-based health center. I understand that this consent will be valid for two years, or until I provide the school-based health center staff written notice of my revocation. All healthcare information is confidential under applicable law.</p> <p>I understand that my consent permits the school-based health center staff to communicate my child's health information on an as needed basis with the school nurse and your child's regular doctor (if applicable) with the understanding that this information will continue to be treated as confidential under applicable law. No student will be denied access to health care services due to the inability to pay. When available, insurance or Medicaid will be billed. I consent to the health center releasing information regarding treatment to third party payors for billing purposes.</p> <p>I understand that confidentiality between my child and the health center staff will be maintained for certain services in accordance with applicable law. By law, some information requires your child's written consent prior to disclosure to anyone, including parents/guardians. The health center staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes, a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the health center clinician/staff and the alternative contact.</p>		
SIGNATURE _____		DATE _____