Bayhealth

School-Based Wellness Center-Registration & Health History

Patient Label

Services **will not** be provided unless all sections of this form are complete. **(PLEASE PRINT CLEARLY IN INK)**

Student Name: _____ **Birthdate** ___/_____/____ **Age:** _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Student Phone: (Home) _____ (Cell) _____ **Grade:** _____

Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Student's Preferred Language: ☐ English ☐ Spanish ☐ Other please list_____

Race: Please check ✓all that apply
☐ American Indian/Alaska Native
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White/Caucasian

Name of Student's Medical Provider (Doctor): _____

Address: _____ Phone: _____

☐ **NO PHYSICAN OR MEDICAL PROVIDER**

Name of parent/legal guardian: _____ Relationship to child__

Parent/guardian Phone: (Home) _____ **(Cell)** _____ **Email:** _____

INSURANCE INFORMATION IS REQUIRED TO PROCESS STUDENT VISITS AND A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED

Please indicate your medical coverage. ☐ **NO MEDICAL COVERAGE**

☐ **PRIMARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: _____/_____/_____ Relationship to child: _____

☐ **Medicaid#** _____

☐ **SECONDARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate:_____/_____/_____ Relationship to child: _____

☐ **Medicaid#** _____

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A COMPLETE AND ACCURATE HEALTH HISTORY IS NEEDED IN ORDER FOR THE STAFF TO PROVIDE QUALITY HEALTH CARE.

ALLERGY HISTORY

☐ No Allergies

☐ Medication Allergy (please list): _____

Allergy to: ☐ Latex ☐ Peanuts ☐ Eggs ☐ Other (please list) _____

MEDICATIONS: Please list all medications child is currently taking: prescription, over the counter, herbal supplements

Name of medication Dose Reason for use

_____

_____

_____

FAMILY HEALTH HISTORY-Please check ✓ and indicate which blood relative (i.e. parents, grandparents, siblings) have had the following:

☐ Asthma	☐ Anxiety	☐ Depression
☐ Diabetes	☐ Heart Disease/Attack	☐ High Blood Pressure
☐ Kidney Disease	☐ Sickle Cell	☐ Stroke
☐ High Cholesterol	☐ Blood Clots in legs/lungs	☐ Cancer
☐ Obesity	☐ Other:	

STUDENT HEALTH HISTORY

Please check ✓ any of the following conditions that your son/daughter has now or has had in the past.
Indicate with (P)-Past or (C)-Current. Please provide an explanation below for any **CURRENT** problem checked.

☐ ADD/ADHD	☐ Anemia	☐ Anxiety	☐ Asthma
☐ Cancer (type):	☐ Chicken Pox –year:	☐ Cholesterol (high)	☐ Clotting Disorder
☐ Concussion	☐ Depression	☐ Diabetes	☐ Eating Disorder
☐ Headache-Migraine	☐ Hearing Loss	☐ Heart Murmur	☐ High Blood Pressure
☐ Overweight/Obesity	☐ Learning Disability	☐ Rashes/Skin problem	☐ Seizures
☐ Self-injurious Behavior	☐ Physical Limitations	☐ Suicide Attempts	☐ Smokes/Chew Tobacco
☐ Trauma/Violence	☐ Ulcer/Reflux	☐ Vision Problems	☐ Other:

Explanation of CURRENT illness or problems: _____

_____

List all past surgeries:

Type of Surgery	**Date**
	Date / /
	Date / /

Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness staff to address? ☐ Yes ☐ No

If yes, what are your concerns? _____

_____

Is your teen currently receiving counseling or mental health services: ☐ Yes ☐ No

Name of Counselor/Facility: _____

I have read this form carefully and ***I acknowledge*** that all information requested on the Registration & Health History Form is accurate and complete.

Signature of Parent/LegalGuardian: _____ Date: ____ _/ /_____