Healthy Kids Clinic
A Part of Cumberland Family Medical Center, Inc.
PO Box 2399 · Russell Springs, KY 42642
Toll Free: 844.435.0900
www.healthykidsclinics.com

Dear Parent/Guardian:

Please complete and sign the attached Healthy Kids Clinic school health forms for your student. Below is an explanation of each document.

- Healthy Kids Clinic Registration Form: This is your student's school health registration form for the 2019-2020 school year. It is very important that you complete and sign this form **even if you only want school nurse services.**
- Healthy Kids Clinic Initial History Form: **Only complete this form** if you would like for your child to receive a well child exam from the school-based health care provider.
- Healthy Kids Clinic Dental Exam Form: **Only complete this form** if you give consent for your student to receive their dental screening and cleaning from the dental staff at their school.
- Healthy Kids Clinic Behavioral Health Form: **Only complete this form** if you give consent for the Healthy Kids Clinic behavioral health team or healthy kids clinic staff to speak to your child in a crisis situation as indicated by school district staff.

Parents/guardians will be contacted prior to sick visits to confirm consent. If a parent/guardian would like to be contacted prior to a well child exam, please mark that option on the Healthy Kids Clinic Initial History Form. If your student needs immunizations and you would like to use Healthy Kids Clinic for this service a separate consent will be sent home with your student.

If you have questions regarding school health please contact your school nurse or our Healthy Kids Clinic administrative office at 1-844-435-0900. We look forward to working with you this school year!

Sincerely,

The Healthy Kids Clinic

Healthy Kids Clinic Registration Form *Students*

District: ______________________
School: ______________________
Grade/Teacher: ______________________

PATIENT INFORMATION

Please complete the following information about your child:

Child's Last Name: First: Middle:	Date of Birth:	Social Security Number:

Guardian's First and Last Name:	Guardian's First and Last Name:	Child's Last Name at Birth:	Sex: ☐ M ☐ F

Street Address:	P.O. Box:

City:	State:	ZIP Code:

Guardian Home Phone Number:	Guardian Cell Phone Number:	Guardian Work Phone Number:

Emergency Contact Name & Phone Number (Other Than Guardian):
Additional Emergency Contact Name & Phone Number (Other Than Guardian):

What pharmacy do you use? City: Phone:

Language: ☐ English ☐ Spanish ☐ Other: ______________________

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native American or Alaskan Native ☐ Native Hawaiian or Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

How many people live in your home?	What is your annual household income?

Who is your child's primary care physician?
Phone: Fax:
Would you like for your visit notes to be sent to your primary care physician? ☐Yes ☐No

MEDICAL INSURANCE INFORMATION

If your child has a Medicaid card, KCHIP card, or Private Insurance, please complete the information below for your insurance to be processed in the event your student is seen by Healthy Kids Clinic.

Primary Insurance Company Name:	Primary Insurance Company Address:	Primary Insurance Company Phone Number:

ID Number:	Group Number:

Whose name is on the policy?	Policy Holder's Date of Birth:	Relationship to Patient:

Address of policy holder, if different than patient:

Secondary Insurance Company Name, Address, Phone, ID, Group #:

☐ Check this box if you do not have medical insurance, and you will be contacted by our Patient Financial Services department if seen by the provider.

HEALTHY KIDS CLINIC

Initial History Form for Well Child Exam

Only complete this form if you would like Healthy Kids Clinic to complete your student's well child exam (annual physical).

Childs Name:________________________________ Date Of Birth:___________________________

Guardian Name & Phone Numbers:________________ School & Grade:_________________________

Address:____

Primary Care Physician: ____

Date of Last Well Child Exam or Sports Physical: ______________________________________

Section 1: Please mark the correct response regarding your child's health history. Please provide additional information as necessary.

Allergies: ☐ None ☐ Yes	If yes, please list all allergies and describe reactions.
Current Medications: ☐ None ☐ Yes	If yes, please list medication and dosing information.
Hospitalizations, Major injuries, Surgeries: ☐ None ☐ Yes	If Yes, please describe briefly.
Current Medical Diagnosis: ☐ None ☐ Yes	If yes, please list current diagnosis.
Living Conditions: Number of children living in home: ___	Please mark the response which accurately describes this child's living conditions. ☐ Lives with Family ☐ Lives in group/foster home ☐ Lives Alone
Has child had any of the following:	☐ Chicken Pox ☐ RSV ☐ Meningitis

Section 2: Please check any problems the patient is currently having.

General ☐ unexplained weight gain/loss ☐ poor sleep ☐ fever ☐ headache **Eyes, ears, nose, throat** ☐ wears glasses or contacts ☐ blurred vision/other visual changes ☐ mouth breathing or snoring ☐ loss of hearing or ringing in ears ☐ nasal discharge ☐ hoarseness/sore throat ☐ throat infections ☐ ear infections **Cardiovascular** ☐ chest pain ☐ heart murmur ☐ irregular heart beat/palpitations ☐ congenital heart disease **Pulmonary/lungs** ☐ shortness of breath ☐ persistent cough ☐ coughing up blood ☐ asthma or wheezing	**Neurologic** ☐ blackouts or passing out ☐ seizures ☐ headaches **Gastrointestinal** ☐ poor appetite ☐ refusal to eat ☐ abdominal pain ☐ indigestion ☐ trouble swallowing ☐ diarrhea ☐ constipation ☐ nausea or vomiting ☐ rectal bleeding or blood in bowel movement **Genitourinary** ☐ frequent or painful urination ☐ blood in urine ☐ bedwetting	**Skin** ☐ rash/itching ☐ sores that won't heal ☐ easy bruising ☐ changes in moles **Muscle/joint/bone** ☐ pain or weakness in joints/muscles **Endocrine** ☐ change in tolerance to hot or cold weather ☐ excessive thirst **☐ NO CURRENT PROBLEMS**	**Caretaker Concerns** ☐ dietary habits ________________ ________________ ☐ physical development ________________ ________________ ☐ emotional development ________________ ________________ ☐ attention span ________________ ________________ ☐ behavior ________________ ________________ ☐ academics ________________ ________________ ☐ other concerns ________________ ________________ ________________ ________________ ________________ ________________

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Consent for School Based Behavioral Health Assessment/Consultation in **CRISIS SITUATION ONLY**

In the event of a crisis, a Healthy Kids Clinic Behavioral Health professional may be asked to provide an assessment or consultation for your student. Your signature below permits our staff to provide behavioral health services in an emergency situation.

Furthermore, I give consent for the Healthy Kids Clinic Staff, Board of Education staff, the school nurse and my child's primary care provider to communicate and share medical and psychological conditions on an as needed basis with the understanding all information will be treated in a confidential matter. I understand that this consent form will be valid for the 2019-2020 school year.

Students Name:______________________________ Date of Birth:____________________

School:___________________________________ Grade:_________________________

Guardian Signature:___________________________ Date:__________________________