Student Name_____ Date of Birth_____

HEALTH INFORMATION

Patient's Doctor _____ Patient's Dentist_____

Pharmacy_____ Address_____

Please circle if your child has ever had allergies to any of the following:

Bee sting - Yes / No If yes, does your child have a prescription for an EpiPen? Yes / No

Food Allergies - Yes / No If yes, please list_____

Medications - Yes / No If yes, please list_____ _____

PAST/CURRENT MEDICAL HISTORY - Please Check All That Apply

☐ ADD/ADHD	☐ Diarrhea	☐ Mononucleosis
☐ Anemia	☐ Drug/Alcohol	☐ Mumps
☐ Asthma	☐ Ear Infections	☐ Pneumonia
☐ Bed Wetting	☐ Epilepsy/Seizures	☐ Rheumatic Fever
☐ Birth Defects	☐ Fainting	☐ Scoliosis
☐ Bladder Problems	☐ Hearing Problems	☐ Sinus Problems
☐ Cancer	☐ Heart Problems	☐ Speech Problems
☐ Cerebral Palsy	☐ Hepatitis	☐ Stomach Problems
☐ Chicken Pox	☐ Kidney Disease	☐ Thyroid Disease
☐ Constipation	☐ Lead Poisoning	☐ Tuberculosis
☐ Convulsions	☐ Measles	☐ Urinary Disease
☐ Diabetes	☐ Mental Illness/Depression	☐ Other_____

RACE, LANGUAGE AND HOUSING STATUS

Student Race (Check one)

- ☐ White/Caucasian
- ☐ American Indian/Alaska Native
- ☐ Hispanic/Latino
- ☐ Black or African American
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Asian
- ☐ More than one race
- ☐ Race not reported - Refused

Housing Status (Check one)

- ☐ Not Homeless
- ☐ Homeless Shelter
- ☐ Public Housing

Ethnicity

- ☐ Not Hispanic or Latino
- ☐ Hispanic or Latino

Language

- ☐ English
- ☐ Spanish
- ☐ Other_____

Are there any services you do not wish for your child to receive at the Wellness Center? _____

Parent/Guardian Signature_____ Date _____