PATH
Pender Alliance for Teen Health

School-Based Health Center Patient Information Form

Section I: Patient/Student Information
Social Security #:
Patient/Student Name (first, mi, last):
Birth Date: Gender: ☐ Male ☐ Female Grade Level: School:
Mailing Address:
City: State: Zip Code:
Home Phone: Cell Phone: Work Phone:
Race: (if your Ethnicity is Hispanic/Latino, please select White or Black) ☐White ☐Black ☐ Asian ☐Native American ☐ Alaskan Native ☐ Native Hawaiian ☐ More than one Race ☐ Other
Ethnicity: ☐Hispanic/Latino ☐Other
Section II: Parent/Guardian-Person Responsible for Bill (if different than above):
Name (first, mi, last): Relation to Student:
Birth Date(MM/DD/YY): Gender: ☐ Male ☐ Female
Marital Status: ☐ Single ☐Married ☐Divorced ☐ Widowed ☐Legally Separated ☐Unknown
Race: (if your Ethnicity is Hispanic/Latino, please select White or Black) ☐White ☐Black ☐ Asian ☐Native American ☐ Alaskan Native ☐ Native Hawaiian ☐ More than one Race ☐ Other
Ethnicity: ☐ Hispanic/Latino ☐ Other Are you a Migrant Worker: ☐ Yes ☐ No
Parent Mailing Address:(If different from student)
City: State: Zip Code:
Section III: Emergency Contact
Name (first, mi, last): Phone Number:
Section IV: Insurance Information: Please Provide Copy of Card (front and back)
Type: ☐Medicaid ☐Medicare ☐Private Insurance ☐No Insurance
Ins. Co. Name:
Claim Member ID# : Group # :
Policy Holder Name:
*Documentation for proof of income for the household is needed for those with private insurance or no insurance within 10 days so that any bill to the patient may be put on a slide fee scale. Please call the School Health Center with any questions.
Section V: Preferred Pharmacy
Name of Pharmacy: Location of Pharmacy:
Section VI: Health History
Who is your child's regular Doctor/Provider? ☐ Don't have a regular Doctor
Has your child had a physical in the last year? ☐ Yes ☐ No
Does your child have a regular dentist? ☐ Yes ☐ No
Is your child allergic to any types of foods or medicines? ☐ Yes ☐ No *If yes, list:
Is your child currently taking any medication? ☐ Yes ☐ No *If yes, list:
Has your child had any **serious injury** or been hospitalized **overnight**? ☐ Yes ☐ No *If yes, list reason:
Has your child had any of the following: ☐ADHD ☐Asthma ☐Bleeding Problems ☐Cancer ☐Diabetes ☐Depression ☐Eating/Emotional Disorder ☐Heart Problems ☐High Blood Pressure ☐Kidney Problems ☐Migraines ☐Seizures ☐Sleeping Disorder ☐Stomach Problems ☐Thyroid Problem ☐Other, not listed:

*I give consent for my child,_____ to receive health care services, including required immunizations and flu shots, provided by the staff, and contracted staff, at the School Health Center and to share appropriate health information with each other, with the provider you listed above, with the school nurse, and with other school personnel when it may benefit the child's educational setting. I understand that this consent form will be good until my child leaves/graduates school or until I provide the center with written directions otherwise. I authorize the release of any medical information necessary to process insurance claims and payment of medical benefits for services rendered.

***Parent/Guardian Signature**_____ **Date**_____