Insurance Information

Please complete this information below and return the information with your signature to the Hancock County School Based Health Center

Child's Information

Child's Legal Name: _____ Date: _____

Phone number: _____ Birth Date: _____ SSN: _____

Address: _____

Covered by an insurance plan? Yes__ No__ If Yes, please fill in the appropriate section below.

Medicaid Information

Medicaid ID#: _____Member ID#_____

Private Insurance Information

Insured Parent/Legal Guardian: _____

Birth Date of Card Holder: _____ SSN of Card Holder: _____

Address (if different from child): _____

Place of Employment: _____

Insurance Company and Complete Address: _____

_____

Insurance Company Phone Number: _____

Group Number: _____ ID Number: _____

From (month/year): _____ To (month/year): _____

Parent Signature_____ **Date**_____

HANCOCK COUNTY SCHOOL BASED HEALTH CENTER
STUDENT HEALTH QUESTIONNAIRE

Child's Name: _____ _____ _____
Last First Middle Initial

Date of Birth: _____ Age: _____ Grade: _____ Student ID #: _____
Month/Date/Year

Today's Date: _____ School Name: _____
Month/Date/Year

The information you provide is **STRICTLY CONFIDENTIAL.** Its purpose is to help us give your child better care. We ask that you fill out the form completely, but you may skip any question you do not wish to answer.

Family Information

Your Name	How are you related to the above named child?

1. With whom does your child live? (Check All That Apply)

_____ both natural parents _____ stepmother _____ alone
_____ mother _____ stepfather _____ brother(s)/ages: _____
_____ father _____ guardian _____ sister(s)/ages: _____
_____ adoptive parents _____ other (explain) _____

2. Does anyone else take care of your child? □ Yes □ No
If yes, who? _____
3. Does your child have any health problems? □ Yes □ No
If yes, what? _____
4. Where do you take your child when he/she is sick? _____
5. Where do you take your child for dental care? _____
6. Does your child have any allergies to any medications? □ Yes □ No
If yes, what? _____ Type of reaction _____
7. Is your child taking any medications (over the counter, prescription, homeopathic or herbs)? □ Yes □ No
If yes, what? _____
8. Has your child ever been hospitalized or had surgery? □ Yes □ No
If yes, when? _____ Where? _____ Why? _____
9. Do you have any concerns about your child? □ Yes □ No
If yes, what? _____
10. Are the child's parents: (Please Circle Answer) Married Separated Divorced Non-Married Parents
If divorced, when? _____
11. Do the child's parents work outside the home? □ Yes □ No
If yes, what type of work do they do? Mother _____ Father _____

Family Medical History

12. Does the child's mother, father, siblings or grandparents have any of the following?

		If yes, who?			**If yes,** who?
High Blood Pressure	□ Yes □ No		Learning Problems	□ Yes □ No	
Diabetes	□ Yes □ No		Mental Illness	□ Yes □ No	
Lung Problems	□ Yes □ No		Nerve Problems	□ Yes □ No	
Asthma	□ Yes □ No		Drinking Problems	□ Yes □ No	
Heart Problems	□ Yes □ No		Drug Problems	□ Yes □ No	
Cancer	□ Yes □ No		Other _____	□ Yes □ No	
Miscarriages	□ Yes □ No				

Family Health Habits

13. How often does your child use a seatbelt (car seat)? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

14. Does your child ride a bicycle, skateboard or roller blade? □ Yes □ No

If yes, how often does he/she use a helmet? (Please Circle Answer)

A. Never B. Rarely C. Sometimes D. Often E. Always

15. Does your child need information about safety (strangers or unknown adults, matches, etc.)? □ Yes □ No

16. How many hours of sleep does your child get each night? _____ hours.

17. Do you feel that you live in a unsafe place? □ Yes □ No

18. Have there been any major changes in your family such as: (Check All That Apply)

___ moving ___ death of family member ___ violence or serious accident

___ physical, emotional, sexual abuse ___loss of job ___ birth ___ other

19. Do you have a gun at home? □ Yes □ No

If yes, is it locked? □ Yes □ No

20. Does anyone in your household smoke? □ Yes □ No

21. Do you currently smoke cigarettes? □ Yes □ No

If yes, how many cigarettes do you smoke per day? _____ cigarettes a day

School History

22. Did/does your child attend preschool? □ Yes □ No

23. Do you have any concerns about your child's school performance? □ Yes □ No

If yes, what? _____

24. Do you have any concerns about your child's relationships with teachers? □ Yes □ No

25. Do you have any concerns about your child's relationships with other students? □ Yes □ No

26. Do you have any concerns about your child's relationships with siblings or other family members? □ Yes □ No

27. If over 4 years old, does your child have a best friend? □ Yes □ No

28. Does your child participate in sports/exercise or have hobbies, special interests or talents? □ Yes □ No

If yes, what _____ How often? _____ How long? _____

CHILD'S MEDICAL HISTORY

NAME_____BIRTHDATE_____TEACHER_____

ILLNESS HISTORY

Allergies	__Yes__No
Allergic to drugs	__Yes__No
Anemia	__Yes__No
Asthma	__Yes__No
Other Respiratory Problems	__Yes__No
Stomach Ulcers	__Yes__No
Abdominal Pain	__Yes__No
Constipation/Diarrhea	__Yes__No
Serious Digestive Problems	__Yes__No
Chicken Pox Age____	__Yes__No
Ear Problem	__Yes__No
Ear Infections	__Yes__No
Hearing Aid	__Yes__No
Eye Problem	__Yes__No
Wears Glasses	__Yes__No
Physical/Sexual Abuse	__Yes__No
Fainting Spells/Knocked Out	__Yes__No
Frequent Sore Throat	__Yes__No
Headaches	__Yes__No
Heart Murmur	__Yes__No
Heart Problems	__Yes__No
High Blood Pressure	__Yes__No
Thyroid Problems	__Yes__No
Diabetes	__Yes__No
Hepatitis	__Yes__No
Injuries (major)	__Yes__No
Musculo-Skeletal Problems	__Yes__No
BrokensBones	__Yes__No
Problems Walking	__Yes__No
Kidney/Urinary Tract Problems	__Yes__No
Frequent Colds	__Yes__No
Lung Problems	__Yes__No
Menstration Started Age____	__Yes__No
Menstrual Problems	__Yes__No
Premature Birth Weight_____	__Yes__No
Obese	__Yes__No
Skin Rashes	__Yes__No
Serious Acne	__Yes__No
Sickle Cell Disease	__Yes__No
Sickle Cell Trait	__Yes__No
Other Blood Disorders	__Yes__No
Seizures/Epilepsy	__Yes__No
Speech Problem	__Yes__No
Tuberculosis	__Yes__No
Cancer	__Yes__No
Other_____	__Yes__No

BEHAVIOR STUDY

Eating Problems	__Yes__No
Thumb Sucking	__Yes__No

BEHAVIOR STUDY (Cont'd)

Nightmares	__Yes__No
Bedwetting	__Yes__No
Discipline Problems	__Yes__No
Overactive/Hyperactive	__Yes__No
Shy	__Yes__No
Sleeping Problems	__Yes__No
Slow Development	__Yes__No
Learning Disability	__Yes__No
Smoker	__Yes__No
Alcohol	__Yes__No
Inhalants	__Yes__No
Other Drugs _____	__Yes__No
Depression	__Yes__No
Other Behavior Problems	__Yes__No
Other Mental Problems	__Yes__No
Other_____	__Yes__No

Explain any behavior or mental problems noted _____

_____

_____

PLEASE LIST ANY PRESENT CONCERNS:

_____

_____

_____

***Explain any illnesses marked yes:

_____

_____

_____

_____

DENTAL

Dental Problems	__Yes__No
Meningitis	__Yes__No
AIDS/HIV	__Yes__No
Rheutmatic Fever	__Yes__No
Hemophilia	__Yes__No
Underweight	__Yes__No

When was your child's last dental visit?

_____

How often are your child's teeth brushed?
__Occasionally __Once a Day __Twice __Other

Has your child had a toothache recently? _Yes _No

Has your child had any injury to the teeth or jaws? __Yes __No

Does your child have a finger or thumb sucking habit?

Generally speaking, what has been your child's experience with a dentist? __Good __Bad __Very Bad
__No experience (the child's first visit)

What is the best way to reach you, if we need to? Home Phone #_____ Cell Phone # _____

Mailing Address _____

THANK YOU!

Parent Signature_____Date: _____