

**JOHN DICKINSON HIGH SCHOOL WELLNESS CENTER
REGISTRATION/HEALTH HISTORY FORM**

A complete and accurate health history is needed in order for Center staff to provide high quality health care. Services will not be provided unless these forms are completed. Please circle appropriate initials for answers when indicated.

Student's Name _____ Student's Sex: M F Grade in School: 9 10 11 12

Address: _____ Parents Daytime Phone # _____

_____ Zip: _____ Home Phone # _____

Date of Birth: ____/____/____ SSN: _____

Race: **I** American Indian/Alaska Native **B** Black/African American **W** White **O** Other
N Native Hawaiian/Other Pacific Islander **M** Mixed **A** Asian

Hispanic-American Indian/Alaska Native, **Hispanic**-Black/African American, **Hispanic**-Asian,
Hispanic-White, **Hispanic**-Native Hawaiian/Other Pacific Islander

Household Student lives with (circle all that apply):

MC Both Parents MH Father only FC Mother only
SE Lives alone/independent SP Student is a Parent Ex Extended Family/Relative (s)

Is the home address you provided above: P Permanent S Shelter I Institution O Other
U Unstable/Temporary F Foster Care H Host Family (AFS)

Will your son/daughter be participating in the State Subsidized School Lunch Program this year? Y N

Is your son/daughter enrolled in Special Education courses? Y N

What is your son/daughter's usual source for acute care (where do you take him/her when he/she is sick)?

P Private Doctor (Name _____) C Community Health Center (Name _____)
PHC Public Health Clinic (Name _____) E Hospital Emergency Room (Name _____)
N None HO Hospital Outpatient (Name _____)
O Other (please explain _____)

What is your son/daughter's source for primary care (where do you take him/her for well visits, physicals, immunizations, etc.?)

P Private Doctor (Name _____) C Community Health Center (Name _____)
PHC Public Health Clinic (Name _____) E Hospital Emergency Room (Name _____)
N None HO Hospital Outpatient (Name _____)
O Other (please explain _____)

Has your child seen a health provider in the last year? Y N

If yes, please indicate the # of visits _____ and the reason for seeking care (circle all that apply):

AM Acute Illness-Minor AS Acute Illness-Serious MH Mental Health Counseling PE Physical Exam
DA Developmental Assessment FP Family Planning OHS Other Health Screening CD Chronic Disease
SA Substance Abuse IMM Immunizations IM Injury-Minor IS Injury-Serious
O Other (please specify) _____

Has your child seen in an Emergency Room in the last year? Y N

If yes, please indicate the # of visits _____ and the reason for seeking care (circle all that apply):

AM Acute Illness-Minor AS Acute Illness-Serious MH Mental Health Counseling PE Physical Exam
DA Developmental Assessment FP Family Planning OHS Other Health Screening CD Chronic Disease
SA Substance Abuse IMM Immunizations IM Injury-Minor IS Injury-Serious
O Other (please specify) _____

What is your son/daughter's usual source of Dental Care?

P Private Dentist/Dental Practice MC Military Dental Clinic C Clinic N Non Usual Source O Other

Has your son/daughter been seen for a dental visit in the last year? Y N

Do you need help finding a primary care provider/physician for your child? Y N

Do you need help finding medical insurance for your child? Y N

Date of student's last Tetanus (Td or DTP) shot: _____ Date of student's last Measles (or MMR) shot: _____

Date of Hepatitis B Vaccine _____ Date of last PPD (skin test for Tuberculosis): _____

(PLEASE COMPLETE THE OTHER SIDE)

