#### **Valley Health Care, Inc. School-Based Health Clinic**

####  **Health Update Form (Grades PK-12)**

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| **If you have questions about this form, the services we provide or would like help completing this form please call our SBHC Cell Phones at (304)-614-5473 or (304)-642-4565 to speak with one of our SBHC staff.****Information**Valley Health Care, Inc. and the Randolph County Board of Education have partnered to bring School-Based Health to your child’s school. At your School-Based Health Center, there are licensed healthcare clinicians to provide on-site medical care. School-Based Health Centers have been shown to improve both health and academics, reduce absenteeism and increase access. With enrollment, your child can be seen at the School-Based Health Center quickly and without you having to leave home, take off time from work, or find a ride. Our goal is to offer convenient, comprehensive care to your child in conjunction with your child’s regular primary care provider (PCP).  |
| **Student’s Last Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Student’s First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ *Month Day Year***Student’s Social Security Number:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Gender**: ❑ Male ❑ Female ❑ Trans **Ethnicity**: ❑ Hispanic ❑ Non-Hispanic**Race**: ❑ Hispanic ❑ Black ❑ White ❑ American Indian ❑ Asian/Pacific Islander ❑ Other \_\_\_\_\_\_\_\_\_\_\_\_\_**Student Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *City State Zip Code***Who is the student’s regular doctor?**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Prefered Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Does the student/patient see a counselor or have Behavioral Health Services: \_\_\_Yes \_\_\_NoProvider/Agencies name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Mother**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Father**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Legal Guardian, If Applicable**Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship of legal guardian to student❑ Grandparent ❑ Aunt or Uncle ❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**Contact Information for parent or guardian**Home Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Consent to Text: ❑Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Additional Emergency Contact(s)**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home/Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **INSURANCE INFORMATION** |
| **Does your child have Medicaid?**❑ No ❑ Yes: Medicaid ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Does your child have CHIP?**❑ No ❑ Yes: CHP # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**If your child does not have health insurance, would you like to be contacted by a representative of a community organization or a WV State approved low-income health insurance plan?**❑ No ❑ Yes  | **Does your child have other insurance?**❑ No ❑ Yes: Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Coverage Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Policy Holder’s Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Policy Holder’s First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**: \_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_ *Month Day Year* |

Medical Allergies

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Is the Student/Patient allergic to or has had a reaction to:** | **Yes** | **No** |  | **Yes** | **No** |
| Any medicines (Penicillin or other antibiotic) | ☐ | ☐ | Local anesthetics (including lidocaine) | ☐ | ☐ |
| Any foods (including lactose intolerance) | ☐ | ☐ | Latex | ☐ | ☐ |
| Please explain any allergies:  |

**Is the Student/Patient taking any prescription and/or non-prescription medications including vitamins, nutritional supplements, contraceptives, pain relievers, diuretics, laxatives, herbal remedies, or allergy medications? ☐Yes ☐No Please list medications below.**

|  |  |  |
| --- | --- | --- |
| **NAME OF MEDICATION** | **DOSE** | **FREQUENCY** |
|  |  |  |
|  |  |  |
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|  |  |  |

The School-Based Health Center has my permission to administer the following medications at the discretion of the medical provider. Please check.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Yes** | **No** |  | **Yes** | **No** |
| Tylenol/Acetaminophen | ☐ | ☐ | Motrin/Ibuprofen | ☐ | ☐ |
| Cough Drops | ☐ | ☐ | Tums/Maalox | ☐ | ☐ |
| Cough Syrup | ☐ | ☐ | Zofran | ☐ | ☐ |
| Mucinex | ☐ | ☐ | Benadryl | ☐ | ☐ |
| Orajel | ☐ | ☐ | Zyrtec or Claritin | ☐ | ☐ |
| Hydrocortisone Cream | ☐ | ☐ | Albuterol (Breathing treatment) | ☐ | ☐ |

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| Any changes in your family history? |
| Any changes in your child’s medical history? Any recent surgeries or hospital admissions? |
| Any changes in your child’s living or guardian situation? |

I am aware of the services provided by Valley Health Care’s School Based Clinics and my signature provides consent for my child to continue to receive the services provided.

**X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 Signature of Parent/Guardian Date