

SEATTLE KING COUNTY PUBLIC HEALTH SCHOOL BASED HEALTH REGISTRATION

Today's Date: _____ Student ID #: _____

Name: First _____ Last _____ Middle Name _____ Suffix: Jr, Sr, I, II, III

Preferred Name or "Nickname" _____ SS# (Optional): _____ - _____ - _____

Gender: _____ Date of Birth: _____

Address: _____ City: _____ State _____ Zip Code: _____

Home Phone: _____ May we call/text you at this number? Yes No

Student Cell Phone: _____ May we call/text you at this number? Yes No

Language Do you need an interpreter? Yes No If Yes, what is your primary language? _____

Housing Status: Have you been in safe and stable housing for the past year? Yes No
If "No" Transitional housing Living with others Shelter Street/Camp/Bridge Other
If other, please describe: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Latino Decline to answer

Race: all that apply: Asian Alaskan Native American Indian Black or African American
 Pacific Islander Hawaiian Native White Decline to answer

When was your last physical exam? Date: _____ **When was your last dental exam?** Date: _____

Primary Care Provider: Do you have a current Primary Care Provider Yes No

If yes, who is your provider? _____ What clinic do you go to? _____

Insurance Information:

Do you have any type of medical or dental insurance coverage?

Yes (If possible, provide medical insurance card at check-in) No

If yes, check all that apply:

Apple Health (Medicaid) Commercial/Private Insurance Other _____

Emergency Contact:

Name: _____ Relationship: _____

Legal Guardian Yes No Phone# _____ Alternate Phone# _____

If this is **NOT** your guardian who is? _____ Phone# _____

Please answer the health history questions if you know (Medical/Mental Health History)

Does the student have any medical or mental health concerns? _____

Does the student have an allergy to any food/medications? _____

Does the student take medication on a regular basis? _____ What medications? _____

Has anyone in the student's family had the following (**check all that apply**).

For any positive please indicate who (Mother/Father/Sister/Brother/Aunt/Uncle/Grand Parent and when is it started).

_____ Asthma _____ Diabetes _____ Heart Problems/Stroke _____ Mental Health
Concerns/Suicide _____ Alcohol or Chemical use _____ Cancer _____ Seizures _____ High Blood
Pressure _____ High Cholesterol _____ Died before 50 _____ Blood Clot