## SEATTLE KING COUNTY PUBLIC HEALTH SCHOOL BASED HEALTH REGISTRATION

| Name: FirstLast  | Today's Date:  | Student ID #:     |                      |                       |                            | -                |
|--|--|-------------------|----------------------|-----------------------|----------------------------|------------------|
| Gender:  | Name: First Last   |                   | Middle Name          |                       | Suffix: Jr, Sr, I, II, III |                  |
| Address:   | Preferred Name or "Nickname"   |                   | SS# (Optional        | ):                    |                            |                  |
| Home Phone:  | Gender: Date   | of Birth:         |                      |                       |                            |                  |
| Student Cell Phone:  | Address:   | City:             |                      | State                 | Zip Code: _                |                  |
| 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       Ott         If other, please describe:  | Home Phone:  |                   | _ May we call/te     | xt you at this n      | umber? 🗆 Yes               | □ No             |
| 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       □Ot         If other, please describe:  | Student Cell Phone:  |                   | May we call/te       | xt you at this n      | umber? 🗆 Yes               | □ No             |
| If "No"       Transitional housing       Living with others       Shelter       Street/Camp/Bridge       Ot         If other, please describe:   | Language Do you need an interpreter?   | ⊐ No If Yes, wha  | at is your primar    | y language?           |                            |                  |
| 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:   | If "No"  | ng with others    | □Shelter             | □Street/Camp          |                            | □Other           |
| <ul> <li>Pacific Islander □ Hawaiian Native □ White □ Decline to answer</li> <li>When was your last physical exam? Date:</li></ul>   | <b><u>Ethnicity:</u></b> $\Box$ Hispanic/Latino $\Box$ Nor   | n-Hispanic/Latir  | io 🗆 Decli           | ne to answer          |                            |                  |
| 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?   |  |                   |                      |                       | k orAfrican Am             | erican           |
| If yes, who is your provider? What clinic do you go to?<br>Insurance Information:<br>Do you have any type of medical or dental insurance coverage?<br>Yes (If possible, provide medical insurance card at check-in)  | When was your last physical exam? Date:  |                   | <u>When was your</u> | <u>last dental ex</u> | am? Date:                  |                  |
| Insurance Information:         Do you have any type of medical or dental insurance coverage?         Yes (If possible, provide medical insurance card at check-in)         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?          Please answer the health history questions if you know (Medical/Mental Health History)         Does the student have any medical or mental health concerns?   | Primary Care Provider: Do you have a current   | nt Primary Care   | Provider             | □ Yes                 | □ No                       |                  |
| Do you have any type of medical or dental insurance coverage?           If yes, (If possible, provide medical insurance card at check-in)       Image: No         If yes, check all that apply:       Image: Other Contact:         Apple Health (Medicaid)       Image: Commercial/Private Insurance       Image: Other Contact:         Name:       Relationship:       Image: Contact:         Name:       Relationship:       Image: Contact:         If this is NOT your guardian who is?       Phone#       Alternate 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?       Image: What medications?       Image: Contact:         Has anyone in the student's family had the following (check all that apply).       Image: Contact:       Image: Contact: | If yes, who is your provider?  | What              | clinic do you go t   |                       |                            |                  |
| Name:  | Do you have any type of medical or dental insu<br><b>Yes</b> (If possible, provide medical insurance of<br>If yes, check all that apply: | card at check-in) | ) 🗆 No               | r                     |                            |                  |
| 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?  | Emergency Contact:   |                   |                      |                       |                            |                  |
| If this is <u>NOT</u> your guardian who is? Phone#   | Name:  | Relationship:     |                      |                       |                            |                  |
| Does the student have any medical or mental health concerns?<br>Does the student have an allergy to any food/medications?<br>Does the student take medication on a regular basis? What medications?<br>Has anyone in the student's family had the following (check all that apply).  |  |                   |                      |                       |                            |                  |
| Does the student take medication on a regular basis? What medications?<br>Has anyone in the student's family had the following ( <b>check all that apply</b> ).  | Does the student have any medical or mental  | health concerns?  | ?                    |                       |                            |                  |
| Has anyone in the student's family had the following ( <b>check all that apply</b> ).  |  |                   |                      |                       |                            |                  |
|  |  |                   |                      | ations?               |                            |                  |
|  | -  |                   |                      | e/Grand Parent        | t and when is it .         | <u>started).</u> |
| AsthmaDiabetesHeart Problems/StrokeMental Health   |  |                   |                      |                       |                            |                  |
| Concerns/Suicide Alcohol or Chemical use Cancer Seizures High E<br>Pressure High Cholesterol Died before 50 Blood Clot   |  |                   |                      |                       |                            | iign Blood       |