NAME_____
SCHOOL_____
TEACHER_____ Grade_____

CHILD'S MEDICAL HISTORY

Please check YES for any health conditions that your child has or had in their lifetime. For Behavior Health and Dental questions, please check YES if your child has been experiencing these issues in the last 12 months.

ILLNESS HISTORY

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

BEHAVIOR HEALTH

Alcohol use	□Yes
Bedwetting	□Yes
Depression	□Yes
Disciplinary problems	□Yes
Drug use	□Yes
Eating problems	□Yes
Hyperactive/Overactive	□Yes
Learning Disability	□Yes
Frequent nightmares	□Yes
Shy	□Yes
Sleeping problems	□Yes
Smoking or inhalant use	□Yes
Thumb or finger sucking	□Yes
Other Behavior Problems	□Yes
Other Mental Problems	□Yes
Other_____	□Yes

Explain any behavior or mental problems noted _____
_____
_____

PLEASE LIST ANY PRESENT CONCERNS:

_____
_____
_____

***Explain any illnesses marked yes:

_____
_____
_____
_____

DENTAL

Dental Problems	□Yes
Pregnant	□Yes
AIDS/HIV	□Yes
Rheumatic Fever	□Yes
Hemophilia	□Yes
Underweight	□Yes

When was your child's last dental visit?

_____

Generally speaking, what has been your child's dental experience?

☐Good ☐Bad ☐Very Bad ☐No prior experience

How often are your child's teeth brushed?

☐Occasionally ☐Once a Day ☐Twice a day ☐Other

Has your child had a toothache recently? □Yes □No

Has your child had any injury to the teeth or jaws? □Yes □No

Revised 8/12/2022

NAME_____
SCHOOL_____
TEACHER_____ Grade_____

Medical Information Release Form (HIPAA Release Form)

Name: _____ Date of Birth: _____/_____/_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

□Spouse_____

□ Child(ren)_____

□ Other relatives_____

□ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call

□ my home _____

□ my work_____

□ my cell number:_____

□ other number:_____

If unable to reach me:

□ you may leave a detailed message

□ please leave a message asking me to return your call

□ other _____

The best day to reach me is _____between_____ am/pm & _____am/pm

Signed: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

I understand the **HEALing Community Center** is permitted to disclose protected health information about my child for the purposes of payment, continued care or treatment, and healthcare operations. If my child's protected health information includes any records containing information related to the treatment of any infectious disease (including AIDS), drug or alcohol abuse and/or mental illness. I hereby give consent to the disclosure of this information by these clinics only as reasonably necessary to accomplish the purposes described above, and I waive any privileges with regard to such disclosure. I also understand that I can withdraw my consent for disclosure of such information at any time except to the extent action has been taken in reliance upon such consent.

I HAVE RECEIVED THE HEALing Community Center SCHOOL HEALTH CLINIC'S NOTICE OF PRIVACY PRACTICES.

_____ _____

(PLEASE INITIAL) **(DATE)**