# Valley Health Care, Inc. School-Based Health Clinic
# Health Update Form (Grades PK-12)

**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 ___No

Provider/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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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) | ☐ | ☐ |

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