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 orAfrican 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