Shaw Family Medical

PATIENT INFORMATION

Student's Name: ______________________________

Student Date of Birth: ____________ Gender: Male___ Female ___

Student Social Security Number: ____________________

1. Child's Medicaid number: ______________________
2. Child's CHIP number:____________________
3. For private insurance, please complete the following:

Name of policyholder: ______________________

Relationship to student: ______________________

Name of insurance company: ____________________

Group #________________Policy #_______________

Guardian Name (Print Please): ______________________

Parent/Guardian's Home Address: ______________________________

City:__________________ZIP:______________

Parent/guardian phone numbers: 1.________________________(home or cell)

2.________________________(Work)

If we are unable to reach you, who else may we contact regarding your child?

Name:____________________Relationship:__________Phone #:____________

Name:______________Relationship:______________Phone #: ____________

Preferred Pharmacy: ______________________________

Signature of Parent/Legal Guardian: ____________________

Printed name of Parent/Legal Guardian:__________________

Date:_______

Shaw Family Medical

CONSENT FOR TREATMENT

Please place a check mark next to the services you consent for your child to receive.

I, ______________________________(parent/guardian's name), grant

permission for my child, ______________________ to receive the medical treatment indicated below. I request that payment of authorized Medicaid or other third party insurance be made to Shaw Family Medical. I authorize any holder of medical information regarding the patient listed above to release such information to the Division of Medicaid or their Fiscal Agent and/or any third party insurance, when needed to determine these benefits.

<u>Please check the box beside the services you consent for your child to receive:</u>

○ COMPLETE PHYSICAL EXAMINATION (including EPSDT* ex:
Medicaid screenings, health/puberty teaching, and limited diagnostic testing).

○ Yes. I authorize my child to receive the Flu Vaccine at his/her school.

Is your child allergic to eggs?
(The flu vaccine is made with an egg component)
yes no (circle one)

○ Yes, I authorize my child to receive the required school shot for 7th grade if needed.

Signature of Parent/Legal Guardian: ______________________________

Printed name of Parent/Legal Guardian: ______________________________

Date: ______________

Shaw Family Medical

YOUTH MEDICAL INFORMATION FORM

MEDICAL HISTORY: (TO BE COMPLETED BY PARENT OR LEGAL GUARDIAN)

Student's Name:______________________________ Date of Birth:________________

List your child's allergies, if any (food, medications, etc.): ______________________________

List your child's daily medications (name of medicine, amount, when taken, etc.): ________________

(Please include any inhalers or nebulizers-include average number of times per week that patient needs rescue medications)

Date of child's last dental exam:____

PLEASE CIRCLE "YES" OR "NO" FOR EACH OF THE FOLLOWING:

Does your child have a medical history of:

Condition		
ADD/ADHD	YES	NO
Allergies	YES	NO
Asthma	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Eczema	YES	NO
Headaches/migraines (frequently)	YES	NO
Hearing Loss	YES	NO
Heart murmur/disease	YES	NO
HIV/AIDS	YES	NO
Inflammatory bowel disease	YES	NO
Jaundice	YES	NO
Lead poisoning	YES	NO
Meningitis	YES	NO
Obesity	YES	NO
Otitis media/ Ear problems	YES	NO
Pneumonia	YES	NO
Scoliosis	YES	NO
Seizures	YES	NO
Sickle Cell	YES	NO
Strep throat (recurring)	YES	NO
UTI (Urinary Tract Infection)/ Kidney problems	YES	NO
Varicella	YES	NO
Vision problems/Wears glasses	YES	NO
Stomach problems/Frequent stomachaches	YES	NO
Problems as a newborn or premature delivery	YES	NO
Permanent physical disability	YES	NO

If you answered "YES" to any of the above, please explain: ______________________________

Signature of parent/guardian: ______________________ Date:________________

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PLEASE CIRCLE "YES" OR "NO" FOR EACH OF THE FOLLOWING:

Does your child have a surgical history of:

Procedure		
Adenoidectomy	YES	NO
Appendectomy	YES	NO
Cleft lip	YES	NO
Cleft palate	YES	NO
Ear tubes	YES	NO
Gastrostomy	YES	NO
Heart Surgery	YES	NO
Inguinal hernia	YES	NO
Lymph node biopsy	YES	NO
Tonsillectomy	YES	NO
Umbilical hernia	YES	NO
VP Shunt	YES	NO
	YES	NO

If you answered "YES" to any of the above, please explain: ____________________

Family History of any of the following **before the age of 55**: Please circle below.

- ☐ Heart diseases / high cholesterol----mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- ☐ High blood pressure-------------------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- ☐ Diabetes--------------------------------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- ☐ Sudden death from heart problems--mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- ☐ Kidney disease-------------------------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- ☐ Asthma / Lung disease-----------------mom / dad / grandma / grandpa / sister / brother / aunt / uncle

****Please notify the clinic if your child's health status changes in any way after turning in this health history*****

Signature of Parent/Legal Guardian: ____________________ Date: __________

Printed name of Parent/Legal Guardian: ____________________

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