



# High School Wellness Center Registration & Health History

|                             |              |
|-----------------------------|--------------|
| Caesar Rodney Wellness Ctr. | 302-698-4280 |
| Dover Wellness Center       | 302-672-1586 |
| Lake Forest Wellness Center | 302-284-9291 |
| Milford Wellness Center     | 302-424-6120 |
| POLYTECH Wellness Center    | 302-697-8402 |
| Smyrna Wellness Center      | 302-653-2399 |
| Woodbridge Wellness Center  | 302-337-9310 |

Services **will not** be provided unless all sections of this form are complete. **(PLEASE PRINT CLEARLY IN INK)**

**Student Name:** \_\_\_\_\_ **Birthdate** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
(Street) (City) (State) (Zip)

**Student Phone:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Gender:**  Male  Female **Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino **Student's Preferred Language:**  English  Spanish  Other please list \_\_\_\_\_

**Race:** Please check  all that apply  
 American Indian/Alaska Native  Native Hawaiian/Pacific Islander  
 Asian  White/Caucasian  
 Black/African American

**Name of Student's Medical Provider (Doctor):** \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**NO PHYSICIAN OR MEDICAL PROVIDER**

**Name of parent/guardian:** \_\_\_\_\_ Relationship to child \_\_\_\_\_

**Parent/guardian Phone:** (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

**INSURANCE INFORMATION IS REQUIRED TO PROCESS STUDENT VISITS AND A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED**

**Please indicate your medical coverage.**  **NO MEDICAL COVERAGE**

**PRIMARY MEDICAL INSURANCE**

Name of Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Student Policy #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to child: \_\_\_\_\_

**Medicaid#** \_\_\_\_\_

**SECONDARY MEDICAL INSURANCE**

Name of Insurance Company: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Student Policy #: \_\_\_\_\_ Group Number: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ Subscriber Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Relationship to child: \_\_\_\_\_

**Medicaid#** \_\_\_\_\_

**A COMPLETE AND ACCURATE HEALTH HISTORY IS NEEDED IN ORDER FOR THE STAFF TO PROVIDE QUALITY HEALTH CARE.**

**ALLERGY HISTORY**

- No Allergies
- Medication Allergy (please list): \_\_\_\_\_
- Allergy to:  Latex  Peanuts  Eggs  Other (please list) \_\_\_\_\_

**MEDICATIONS:** Please list all medications child is currently taking: prescription, over the counter, herbal supplements

| Name of medication | Dose | Reason for use |
|--------------------|------|----------------|
|                    |      |                |
|                    |      |                |

**FAMILY HEALTH HISTORY**-Please check  if any blood relatives (i.e. parents, grandparents, siblings) have had the following:

- |   |   |                                       |
|---|---|---------------------------------------|
| <input type="checkbox"/> High Blood Pressure        | <input type="checkbox"/> Diabetes (sugar)       | <input type="checkbox"/> Stroke       |
| <input type="checkbox"/> Heart Disease/Heart Attack | <input type="checkbox"/> Thyroid Disease        | <input type="checkbox"/> Asthma       |
| <input type="checkbox"/> Kidney Disease             | <input type="checkbox"/> Sickle Cell            | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High Cholesterol           | <input type="checkbox"/> Mental Health Concerns | <input type="checkbox"/> Cancer       |
| <input type="checkbox"/> Overweight                 |   |                                       |

**STUDENT HEALTH HISTORY**

Please check  any of the following conditions that your son/daughter has now or has had in the past. Indicate with (P)-Past or (C)-Current. Please provide an explanation below for any **CURRENT** problem checked.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Learning Disability |
| <input type="checkbox"/> Heart Problems        | <input type="checkbox"/> Tuberculosis            | <input type="checkbox"/> Frequent Anger      |
| <input type="checkbox"/> Ulcers/Reflux         | <input type="checkbox"/> Chicken Pox- year _____ | <input type="checkbox"/> Change in Friends   |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Mood Changes        |
| <input type="checkbox"/> Head Injury/Headaches | <input type="checkbox"/> Skin Problems           | <input type="checkbox"/> Appears Withdrawn   |
| <input type="checkbox"/> Seizures              | <input type="checkbox"/> Weight Concerns         | <input type="checkbox"/> Attempted Suicide   |
| <input type="checkbox"/> Physical Limitations  | <input type="checkbox"/> Drug Use                | <input type="checkbox"/> Anxiety/Depression  |
| <input type="checkbox"/> Vision/Eye Problems   | <input type="checkbox"/> Alcohol Use             | <input type="checkbox"/> Other (Please List) |
| <input type="checkbox"/> Cancer (type) _____   | <input type="checkbox"/> Smokes/Chews Tobacco    |  |

Explanation of CURRENT illness or problems: \_\_\_\_\_

**List all past surgeries:**

| Type of Surgery | Date |
|-----------------|------|
|                 |      |
|                 |      |

Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness staff to address?  Yes  No

If yes, what are your concerns? \_\_\_\_\_

Is your teen currently receiving counseling or mental health services:  Yes  No

Name of Counselor/Facility: \_\_\_\_\_

I have read this form carefully and **I acknowledge** that all information requested on the Registration & Health History Form is accurate and complete.

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

