



# 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: \_\_\_\_\_