

STUDENT INFORMATION

Student Name: _____ /_____/_____
(Last) (First) (M.I.) (Date of Birth)

_____ **Address** _____ **Home Phone**

_____ **City** _____ **State** _____ **Zip Code**

_____ **Mother** _____ **DOB** _____ **Father** _____ **DOB** _____ **Guardian**

_____ **Address** _____ **Address** _____ **Address**

_____ **City, State, Zip Code** _____ **City, State, Zip Code** _____ **City, State, Zip Code**

_____ **Phone** _____ **Phone** _____ **Phone**

1. Does this student have a personal physician who provides medical care to him/her? YES NO

Name of Doctor/Clinic: _____ Phone Number: _____

2. When was the student last seen by his/her physician: _____

3. Does this student have a family dentist? YES NO Dentist Name: _____

Names and ages of all Children in your Family:

Name:	Age:	DOB:	School:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Health Conditions: Does this student have a chronic health condition, which Teen Center should be aware of? If so, Please explain:

Is the student taking any medicine? YES NO Taking any medicine on a regular basis? YES NO

Name of Medicine: _____

Drug Allergies? _____

Billing Information

Is student currently covered by WIC vouchers? YES NO Health Insurance? YES NO

Insurance Company: _____ Phone Number: _____

Policy Number _____ Group/ID Number: _____

Is student covered by Medicaid? YES NO Medicaid Number: _____