VINE SCHOOL HEALTH CENTER

REGISTRATION FORM FOR SERVICE/TREATMENT

☐ **New Patient** ☐ **Established Patient** ☐ **Foster Care/DCS**
(Please check all that apply)

Child's Information

Child's Name:	**Child's Birth Date:**	**Child's Gender: Male Female Other** **Child's Race:**
Child's Social Security Number:	**Current Pharmacy/Address:**	
Child's Address (street, city, and zip code):	**Child's Current School and Grade**	

Legal Guardian's Information: This section must be completed by a biological parent or appointed by the court to be guardian.

Parent (1) Name:	Parent (2) Name:	Child in DCS/Foster Care/Kinship? Yes No ○ **Custody Documents Provided to the Center**
Parent (1) Birth Date:	Parent (2) Birth Date:	Foster Parent Name:
Parent (1) cell phone #:	Parent (2) cell phone #:	Foster parent cell phone #:
Parent (1) Email:	Parent (2) Email:	Case Worker's Name & cell phone #:

Insurance Information: All Services require a form of payment

Insurance Provider: Self-pay None	Policy Number/ Group Number:
Guarantor's Name (If insurance is TNcare, leave blank):	Parent/Guardian's Employer & Phone:

Additional Information about your child:

Child's Current Medication (Prescribed or over the Counter):

Does the child have any allergies? No Yes To What?	Is the child on free or reduced lunch program at school? **No Yes**	Does the child have a Primary Care Provider? **No Yes** **Who?**
Have any mental health problems? **No Yes** **Diagnosis:**	Have any current/past health problems? **No Yes** **Diagnosis:**	Have an IEP or Special Education services? **No Yes** **Disability:**

Authorized Individuals to participate in your child's care at Vine School Health Center:

I consent for Vine School Health Center to disclose personal/physical/mental health information of my child consisting of: appointment information, diagnosis, and/or medical/mental health/medication information/instructions to *(List names of designated persons and contact numbers)*:

Name of Person/Emergency Contact:	Phone #	Relationship to the Child:
Name of Person:	Phone #	Relationship to the Child:

Please initial the following statements:

Initial		I have been provided a copy of the Health Center's Notice of Privacy Practices Agreement to review or can request a copy.
Initial		I give East Tennessee Child's Hospital permission to release health information to the Vine School Health Center regarding my child's evaluation and treatment.
Initial		I give Vine School Health Center permission to release information to Knox County School System regarding my child's care.
Initial		I understand, Vine School Health Center will bill insurances for services. If applicable, services qualify for a sliding scale fee/self-pay.

In order for this child to have services at Vine School Health Center, please sign below:

The Vine School Health Center is a collaborative effort between Knox County Schools and the University of Tennessee, College of Nursing and is located in the Vine Middle Magnet School and with satellite clinics in other schools. I understand that these services, performed when requested by parents or after parents have been contacted by clinic staff, care will be provided by nurses, nurse practitioners, social workers, social work interns, student nurse practitioners, and student nurses, and physicians, and include but are not limited to: well child exams, immunizations, health education, acute illness care, general first aid, mental health counseling, case management, and sport physicals. By signing this form, I am giving my permission for this child to receive services from the Vine School Health Center.

Parent/Guardian's Signature: _____ **Date:** _____

Vine School Health Center

HEALTH AND HISTORY FORM

Vine School Health Center is a comprehensive healthcare and mental health practice. Please complete the following form to your best ability. We use this information, to provide the best services for your child through our care or our research.

Today's Date:	Child's Name:	Child's Date of Birth:
Child's sex:	Child's Gender Identity:	

Health Questionnaire

Birth History:

How long was pregnancy? _____**WKS** **Full term** **Premature**

What hospital was the child born?

Birth weight? **Lbs** **oz**

Did the child/mother have any problems at birth? **Yes** **No** **Unknown**
If yes, what?

Did birth mother abuse drugs/alcohol during pregnancy? **Yes** **No** **Unknown**

If yes, did the child spend time in the NICU due to drug or alcohol exposure at birth? **Yes** **No** **Unknown**

Social History:

Who lives in the home with the child? (Circle all that apply)
Mother Father Grandparent Guardian Sibling(s) _____
Other:

Is the child currently homeless or ever experienced homelessness (ex. living in a shelter or unstable housing)? **Yes** **No** **Unknown**

Any person in the child's previous/current immediate family ever been to, or currently in, prison/jail? **Yes** **No** **Unknown**

Any person in the child's previous or current immediate family ever had a problem with drugs or alcohol? **Yes** **No** **Unknown**

Any person in the child's previous/current immediate family had a mental illness (depression/anxiety) or attempted suicide? **Yes** **No** **Unknown**

Heath History:

Medication Allergies: **Yes** **No**
Food Allergies: **Yes** **No**
Environmental Allergies: **Yes** **No**
If yes to any above, explain:

Any chronic/serious medical diagnosis? **Yes** **No**

Has the child had any serious illness? **Yes** **No**
Has the child ever been hospitalized? **Yes** **No**
If yes, please tell us about the illness, hospitalization, or surgery/procedure:

Medication taken on regular basis (prescription/non-prescription)? **Yes** **No**
If yes, please explain:

Please check if you have any following concerns for your Child:

☐ Asthma/wheezing	☐ Convulsions/seizures	☐ Joint Pain
☐ Heart	☐ Thyroid	☐ Anemia
☐ High Blood Pressure	☐ Diabetes or blood sugar	☐ Fractures
☐ Underweight	☐ Urinary tract infection	☐ Rashes
☐ Overweight	☐ Stomach issues/aches	☐ Fainting
☐ Headaches	☐ Concussion/Head Injury	☐ Hearing
☐ Eye/Vision	☐ Nose	☐ Throat
☐ Ear	☐ Developmental	☐ Behavioral

☐ Other:

Environmental Screener:

Has the child **ever** been verbally abused (put down, devalued, or insulted)? **Yes** **No** **Unknown**

Has the child **ever** been physically abused? **Yes** **No** **Unknown**

Has the child **ever** been sexually abused or assaulted? **Yes** **No** **Unknown**

Has the child **ever** witnessed domestic violence (violence between family members) in the home? **Yes** **No** **Unknown**

If yes, is the abuse still occurring? **Yes** **No**
If yes, please describe:

Has the child often reported feeling neglected, not protected, or were his/her caregiver(s) ever unable to provide basic care? **Yes** **No** **Unknown**

Does the child often report feeling that no one in the family loves him/her or that he/she is not important? **Yes** **No** **Unknown**

Family History

Please Check the box of your child's blood relatives who have ever had any of the following conditions:	Father	Mother	Sibling	F Side	M Side
Asthma					
High Blood Pressure					
Heart attack before age of 50					
Stroke					
Any form of cancer?					
High cholesterol or take medicine for cholesterol?					
Kidney stones, disease, surgery, or transplant?					
Weak immune system or frequent infections?					
Diabetes or blood sugar problems as a child or adult?					
Ulcers of the stomach, Crohn's disease, or other stomach or bowel problems					
Chronic headaches, seizures, or other neurological problems.					