SCHOOL-BASED HEALTH PROGRAM QUESTIONNAIRE ANNUAL UPDATE

Please complete update each year.

Annual Patient Information Update

Child's First Name: _____ Child's Last Name: _____

Today's Date: _____ Child's Grade: _____ Child's Teacher: _____

Child's Social Security Number: _____-_____-_____ Child's Date of Birth: _____ / _____ / _____

Home Address: _____

Primary Phone Number: _____

Language Spoken: _____ Do you need interpreter services? ☐Yes ☐No

Name of Parent/ Legal Guardian: _____Parent/Legal Guardian Date of Birth: _____ / _____ / _____

Relationship to Child: _____

Can we text you with routine reminders? ☐Yes ☐No Number To Receive Messages: _____

ANNUAL HOUSEHOLD INCOME: **PLEASE CIRCLE** your family size and income on the same line.

FAMILY SIZE	100% & below	101% - 150%	151% - 200%	Over 200%	**OTHER:**
1	$0 - $12,490	$12,491 - $18,735	$18,736 - $24,980	$24,981 or more	HOUSEHOLD SIZE:
2	$0 - $16,910	$16,911 - $25,365	$25,366 - $33,820	$33,821 or more	
3	$0 - $21,330	$21,331 - $31,995	$31,996 - $42,660	$42,661 or more	INCOME:
4	$0 - $25,750	$25,751 - $38,625	$38,626 - $51,500	$51,501 or more	
5	$0 - $30,170	$30,171 - $45,255	$45,256 - $60,340	$60,341 or more	

Insurance Information

Insurance: ☐Commercial ☐Medicare ☐Uninsured Medical Insurance Company: _____

☐Medicaid (*Check type*) ☐CDPHP ☐Fidelis ☐MVP ☐United Healthcare ☐Empire Plan ☐Empire BCBS

Cardholder Name: _____ Policy Number: _____ Group: _____

Primary Care Provider Name: _____ Phone Number: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

Name of Child's Dentist: _____ Date of Last Dental Appointment: _____

Emergency Contact Information

We require the name, address and phone number of 2 contacts who can be called if you are unavailable.

Name of Contact : _____Relationship to Child: _____ Phone: _____

Name of Contact : _____Relationship to Child: _____ Phone: _____

PLEASE RETURN TO THE SITE WHERE YOUR CHILD IS ENROLLED IN THE SBHC

Medical Information

Please list any medication that your child takes on a regular basis. (pills, sprays, inhalers, etc.).

Medication	Dosage	When do they take it	Why do they take it

Is your child taking a multivitamin: ☐Yes ☐No Is your child taking a fluoride supplement: ☐Yes ☐No

Does your child have ANY allergies: ☐Yes ☐No If yes, please list and explain reaction: _____

Has your child ever been diagnosed with ANY of the following conditions: ☐Asthma ☐Diabetes ☐ADHD

Does anyone in your family smoke? ☐Yes ☐No If yes, where? ☐ Inside ☐ Outside

Are there any health, social, or academic concerns for your child that you would like to make us aware of?

☐Yes ☐No (If yes, please explain:)

_____

** AS A REMINDER, YOU WILL NOT BE BILLED FOR ANY SERVICES THAT YOUR CHILD RECEIVES AT WHITNEY M. YOUNG, JR. HEALTH CENTER SCHOOL-BASED HEALTH CENTER. The SBHC will bill the student's health insurance for services provided on site at the SBHC. However, services received outside the SBHC (such as lab work) are subject to fees. **

The staff of the School-Based Health Center considers parental/guardian involvement essential in keeping children healthy and will encourage each student to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the School-Based Health Center at any time.

Parent/Guardian Signature: _____ Name:_____

Relationship to Student: _____ Date: _____

Please call your SBHC with any questions. We look forward to a great school year!
To contact your School-Based Health Center office, please call the number below.

Giffen Elementary	Sheridan Prep	Schuyler Academy	Watervliet City School District
518-475-6659	518-475-6708	518-475-6872	518-629-3270

We look forward to serving your child!

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