



MOBILE HEALTH UNIT PROGRAM HEALTH QUESTIONNAIRE (CHILD)
This will confirm your child as an established WYH primary care patient.

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: __/__/____ Gender: Male Female
 Home Address: _____ Family's Annual Income: _____
 Primary Phone Number: _____ Language Spoken: _____
 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: _____

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: _____
 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: _____

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:)

The staff of Whitney Young Health's Mobile Unit considers parental/guardian involvement essential in keeping children healthy and will encourage each child to involve their parents/guardians in health care decisions. We encourage parents/guardians to visit or call the Mobile Unit or Whitney Young Health at any time.

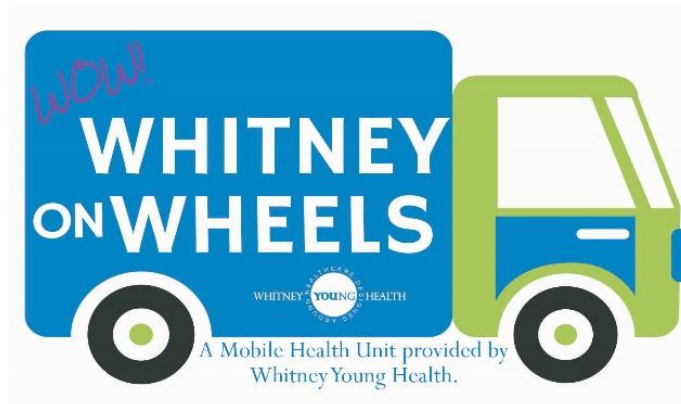
I understand this is a supplement to my original consent to treat. Signed forms are valid at WYH wow sites and WYH center locations unless revoked in writing by the parent or legal guardian.

I understand that every effort will be made to contact me prior to any treatment that requires parental consent according to New York State Law. New York State Law does not require parental consent for treatment or advice about drug abuse, alcoholism, sexually transmitted disease and reproductive health or outpatient mental health services.

I understand that as a WOW patient my child has 24-hour access to WYH by calling 518-465-4771 when WOW is not on site.

Parent/Guardian Signature: _____ **Name:** _____

Relationship to Child: _____ **Date:** _____



PLEASE RETURN TO THE SITE YOUR CHILD WAS SEEN OR TO WYH