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

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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: _____

WOW!
WHITNEY ON WHEELS
A Mobile Health Unit provided by Whitney Young Health.

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