

Nevada Health Centers, Inc.
SCHOOL-BASED HEALTH CENTER
STUDENT DEMOGRAPHICS
 (All information is strictly confidential)

SECTION A: Patient Demographics

Last Name	First	Middle Initial	Birth Date: / /
Street Address	Apt #	City	State Zip
Mailing Address / P.O. Box	Apt #	City	State Zip
Home Phone ()	Cell Number ()	Primary Language: _____ Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non Hispanic	
E-mail Address:			
Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male / Female-to-Male <input type="checkbox"/> Transgender Female / Male-to-Female <input type="checkbox"/> Other <input type="checkbox"/> Chose not to disclose	Sexual Orientation: <input type="checkbox"/> Lesbian or gay <input type="checkbox"/> Straight (not lesbian or gay) <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know <input type="checkbox"/> Chose not to disclose	Preferred Pronoun(s): <input type="checkbox"/> He, Him, His <input type="checkbox"/> She, Her, Hers <input type="checkbox"/> They, Them, Theirs <input type="checkbox"/> Ze, Hir <input type="checkbox"/> Decline to Answer <input type="checkbox"/> Other
Which of the following groups do you feel you belong to? <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Refused to report			
Name of Primary Care Physician			

SECTION B: YES, I have Medical Insurance

Insurance Information (Guarantor)

Insurance Holder's Name as it appears on the insurance card	Date of Birth of Insurance Holder	
Insurance Holder's Employer and Address		
Insurance Plan Name	Subscriber ID	Group Name/Number
Insurance Company Address		

SECTION C: NO, I do not have Medical Insurance

A Financial Counselor will be in contact to provide assistance in your child's care, please provide the following information:

Name	Phone Number ()
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SECTION D: Emergency Contact Information

Name				
Street Address	Apt #	City	State	Zip
Home Phone ()	Cell Phone ()	Work Phone ()	Relationship to Patient	

Nevada Health Centers, Inc.
STUDENT PARENTAL / COURT-APPOINTED
GUARDIAN NOTICE

HIGHLIGHTED AREAS MUST BE COMPLETED FOR SCHEDULING AND REGISTRATION

Please read carefully and complete the following statement acknowledging that your son/daughter/ward may receive services at the Nevada Health Centers School-Based Health Center (NVHCSBHC).

Student Name:	DOB:
School District:	
School:	
Grade: <input type="checkbox"/> Pre K <input type="checkbox"/> K <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12	

I acknowledge that my son/daughter/ward named above may receive the following services at Nevada Health Centers School-Based Health Center (NVHCSBHC):

- | | |
|---|--|
| <ul style="list-style-type: none"> ● Comprehensive health inquiry ● Physical examinations (general, sports, pre-employment) ● Diagnosis and treatment for minor illnesses and injuries ● Screening for select health problems (vision screening, hypertension, etc.) ● Care of certain chronic conditions such as asthma and seizure disorders ● Immunizations as needed (tetanus, measles/mumps, rubella, etc.) ● Individual health and wellness education services | <ul style="list-style-type: none"> ● Routine lab tests ● Prescription medications ● Care for common pediatric/adolescent physical concerns (weight, acne, menstrual problems, etc.) ● Pregnancy testing* ● Birth control management* ● Diagnosis and treatment of sexually transmitted diseases* ● Mental health assessments ● Follow-up care as needed <p style="text-align: center; font-size: small;">* <i>Not applicable in Clark County School District</i></p> |
|---|--|

Financial Responsibility: If you have insurance, Nevada Health Centers will bill your insurance company. Any copays will be billed. If you are uninsured, a Nevada Health Centers financial counselor will be contacting you to explore possible assistance options.

After Visit Summary: If your child/ward receives services in the NVHCSBHC, you/your child will receive an After Visit Summary in a sealed envelope.

Prescriptions: All prescriptions will be electronically prescribed and sent to your preferred pharmacy identified in the School-Based Health Center History Form. Controlled prescriptions will need to be picked up directly from the NVHCSBHC location or the nearest designated Nevada Health Centers physician office.

I certify that I have read this notice and understand its contents.

 Parent / Legal Guardian Signature *(Student can sign if student is 18 years or older)*

 Date

 Relationship to Student

Nevada Health Centers, Inc.

SCHOOL-BASED HEALTH CENTER HISTORY FORM

(All information is strictly confidential)

Student Name: _____ DOB: _____

Please check all that apply:

ALLERGIES	
<input type="checkbox"/> YES, please list below	<input type="checkbox"/> NO KNOWN ALLERGIES
<input type="checkbox"/> Food:	
<input type="checkbox"/> Medications:	
<input type="checkbox"/> Insects:	
<input type="checkbox"/> Seasonal:	
<input type="checkbox"/> Animals:	

PAST MEDICAL HISTORY	
<input type="checkbox"/> Allergies	<input type="checkbox"/> Heart disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Neurological
<input type="checkbox"/> Developmental	<input type="checkbox"/> Behavioral, please list:
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Other, please list:
<input type="checkbox"/> Ear infections	
<input type="checkbox"/> Gastrointestinal	

CURRENT MEDICATIONS			
Name of Medication	Dose	Amount taken	Times per day

PREFERRED RETAIL PHARMACY	
Name:	Phone Number:
Address:	

Please check all that apply:

FAMILY HISTORY	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	OTHER, PLEASE LIST
Alcohol / drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer, type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COPD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Parent / Legal Guardian Signature *(Student can sign if student is 18 years or older)*

Date