La Clínica **SCHOOL-BASED HEALTH CENTERS**

REGISTRATION

☐ **TECHNICLINIC**
Oakland Technical High School Health Center
(510) 450-5421

☐ **TIGER CLINIC**
Fremont High School Health Center
(510) 434-2001

☐ **ROOSEVELT HEALTH CENTER**
Roosevelt Middle School
(510) 535-2893

☐ **SAN LORENZO HIGH HEALTH CENTER**
San Lorenzo High School
(510) 317-3167

☐ **HAWTHORNE CLINIC**
Urban Promise Academy and World & Achieve Academies
(510) 535-6440

☐ **HAVENSCOURT HEALTH CENTER**
Roots, Coliseum College Prep Academy
(510) 639-1981

☐ **YOUTH HEART HEALTH CENTER**
La Escuelita Education Complex
(510) 879-1568

☐ **FUENTE WELLNESS CENTER**
Reach Ashland Youth Center
(510) 481-4554

Medical Record #:

Date _____

Student's Name: _____

Student ID #: _____ Social Security # (if known): _____

School Name: _____ Grade: _____

Student's Address: _____

_____

Birthdate: _____ Gender: ☐ Male ☐ Female ☐ Other _____

Ethnicity: _____

Languages: Primary _____ Secondary _____

What is the best way to reach you? ☐ Cell # _____ ☐ Home # _____

Can we call you at this phone number? ☐ Yes ☐ No

Who should we contact in case of an emergency? _____

Phone number: _____ Relationship: _____

Do you have a regular doctor or clinic you go to? ☐ Yes ☐ No

If Yes, please indicate which:

☐ Children's Hospital Teen Clinic ☐ Clínica Alta Vista ☐ Kaiser

☐ Other doctor or clinic name: _____

MEDICAL INSURANCE INFORMATION

Please fill this out if you have MediCal or other insurance.

☐ MediCal #: _____ ☐ Alameda Alliance for Health ☐ Blue Cross

☐ Alameda Alliance FamilyCare #: _____

☐ Kaiser #: _____

☐ Other Private Insurance (like Health Net): Name of Plan: _____

Member #: _____

☐ No Insurance

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MEDICAL HISTORY

PATIENT I.D. STICKER

PATIENT NAME _____ SEX: M F

MR# _____ DOB:

Student's Name: _____

MEDICATIONS ❑ No Medications

MEDICATION ALLERGIES ❑ No Medication Allergies

OTHER ALLERGIES ❑ No Other Allergies

CHECK ANY ILLNESSES OR HEALTH PROBLEMS YOU/YOUR CHILD HAS NOW OR HAS HAD IN THE PAST

❑ Anemia/low iron	❑ Diabetes	❑ Seizures
❑ Asthma	❑ Gall Bladder Disease	❑ Speech/Hearing Problems
❑ Back Problems	❑ Heart Problems	❑ Stomach Problems
❑ Blood clots	❑ Hepatitis/Liver Disease	❑ Strokes
❑ Blood problems	❑ High Blood Pressure	❑ Surgery/Operations
❑ Blood transfusions	❑ Intestinal Problems	❑ Thyroid Problems
❑ Broken Bones	❑ Kidney/Bladder Problem	❑ Tuberculosis
❑ Cancer	❑ Learning Problems	❑ Vision Problems
❑ Depression	❑ Severe Headaches	❑ Weight Problems

❑ Problem with private parts (ovaries, vagina, uterus, testicles, penis)

❑ Other _____

HAVE ANY FAMILY MEMBERS OR RELATIVES HAD THE FOLLOWING MEDICAL CONDITIONS?

Relationship to child

❑ Bleeding Tendency _____

❑ Cancer _____

❑ Diabetes _____

❑ Heart Attack or Heart Disease _____

❑ High Blood Pressure _____

❑ Mental Illness _____

❑ Seizure _____

❑ Stroke _____

❑ Tuberculosis _____

FORM COMPLETED BY: ❑ Student ❑ Caretaker Date _____

If Caretaker, Name _____