

GENERAL INFORMATION

Please complete the following information for student (**front and back**)
(PLEASE PRINT)

Last Name _____ First Name _____ Middle Name _____

Student's Social Security # _____ **Date of Birth** _____ **Gender: Male / Female**

Race: (mark all that apply) Native American _____ Asian _____ Black or African American _____
Native Hawaiian or Other Pacific Islander _____ White _____

Ethnicity: Hispanic Y / N or Latino Y / N Do you speak English? Y / N If no, what is the primary language? _____

Address _____
Street/PO Box _____ City _____ Zip _____

Mother's name _____ (maiden name) _____ cell # _____ work # _____

Father's name _____ cell # _____ work # _____

Parent's email _____ Home phone # _____ Student's Cell # _____

How many people live in your house? _____

Who does the child live with?

Name _____ Relationship _____ Phone # _____

*** If my child has symptoms of COVID-19, I give permission to administer a Rapid COVID-19 TEST? Yes or No**

Is student covered by Kentucky Medicaid? (Medical Card) **Y / N**

If applicable, circle MCO: AETNA / Well Care / Humana / Molina-Passport / United Healthcare

Policy # as listed on Medicaid or MCO card: _____

Does student have private health insurance? (Not Medicaid) **Y / N** Name of Insurance _____

Does insurance cover ALL immunizations? **Y / N** If not, which ones are not covered? _____

Name of child's primary care doctor _____ phone # _____

Is student in foster care? **Y / N** (If yes, DCBS must sign consent) **Case Worker** _____ **Phone #** _____

In case of an EMERGENCY, if unable to contact a parent/guardian, please provide at least 3 other people we can contact.
(This should be same as school information - Please contact school clinic if phone numbers change)

Name

Relationship to student

Best Contact #

1. _____

2. _____

3. _____

What grade will your child be in during the 2025-2026 school year? _____

Who is your child's homeroom teacher for the 2025-2026 school year? _____

If your child is in Preschool or Head Start, are they in the AM or PM class? _____

Sign on back ➡

Please answer yes/no to the following questions. If the answer is yes - please explain.

1. Allergies (medications, food, latex, etc.) **Y / N** _____

Does your child require an EPI-PEN for his/her allergy? **Y / N**

2. Current medication(s) **Y / N** _____

Are there any over-the-counter medications your child should NOT take? _____

3. Past surgeries/hospitalizations/transfusions **Y / N** _____

4. Has your child had chicken pox? **Y / N** If yes, date diagnosed: _____

Was it diagnosed by a healthcare provider? **Y / N**

4. Long-term illnesses **Y / N** _____

5. Other concerns **Y / N** _____

6. Does anyone smoke inside the home or car? **Y / N** Are E-cigarettes/Juuls smoked inside the home or car? **Y / N**

7. Has your child been in contact with a person with tuberculosis or has your child traveled to or emigrated from a foreign country with a high rate of TB (Asia, Middle East, Africa, or Latin America)? **Y / N** _____

8. Has your child been exposed to the following risk factors for lead poisoning: peeling paint in a house built before 1978, a close family member with lead poisoning, a family member with an occupation that has lead exposure, living closely to a highly traveled highway, using folk remedies containing lead, eating food stored in old pottery, chewing on paint chips or eating dirt? **Y / N** _____

Family history (student's parents, grandparents, siblings): diabetes, stroke, elevated blood pressure, heart disease, TB, cancer, kidney disease, seizures, sickle cell, genetic/birth defects, HIV, or mental health problem(s)

CONSENT TO HEALTH SERVICES

I give my consent for _____ to receive services at the Hopkins County
(Student's Name) (Birth Date)

Health Department School-Based Clinic. Services might include: required school examinations, TB skin test, lead & urine test for Head start students, first aid, Well Child exam or preventive dental screening. This consent will include permission to receive over-the-counter medications such as: Tylenol, Tums, decongestants, cough medicine, anti-nausea medicine, Ibuprofen, antihistamines, etc. I verify that I have received notice of privacy practice. **If Applicable**, I authorize billing for Medicaid services.

Signature of Parent/Guardian

(If student is in foster care, consent must be signed by DCBS Case Worker)

(If you have custodianship of student, we need a court order, notarized Power of Attorney or notarized Caregiver Affidavit)

Date

Student should return form to homeroom teacher or school clinic. Consent is for the 2025-2026 school year.

Child cannot be seen in the school clinic without a signature from the parent, legal guardian, or Community Base Services' (DCBS) case worker.