NORTH VALLEY PROFESSIONAL CENTER

a Division of North Valley Hospital

Columbia

Falls School District #6

School-Based Health Clinic

HEALTH HISTORY FORM

Because young adolescents go through rapid physical and emotional changes, have significant risks to their health, and may have difficulty obtaining health services, we provide the following services:

A) Physical exams and sports physicals
B) Health care for illnesses and injury
C) Health education for students
D) Follow-up for chronic conditions
E) Behavioral health assessment and treatment

For assistance completing this form, please call:
North Valley Professional Center at: (406) 892-3208

Please read this form carefully, complete and sign for your child to receive health services.

NAME OF CHILD: _____
(Please list child's name as it appears on birth certificate)

_____ _____
Parent/Guardian Name (please print) Relationship to Child

_____
Mailing Address City State Zip

_____ _____ _____
Home (H) Phone Number Cell (C) Phone Number Work (W) Phone Number
Which number is your primary day-time contact number? H, C, W May we contact you at work: Yes No

Student's Birth Date____/____/_____ Grade: _____ Social Security Number_____/_____/_____
(It is very important we have this number if we are filing for insurance payment for services)

Sex (circle): Male Female Race (circle): Caucasian African American Other

INSURANCE INFORMATION:

_____ _____
Insurance Name Insurance Address

_____ _____
Subscriber Subscriber Number/Group Number

Please list an alternate contact (adult relative or friend) that will know how to contact you in case of an emergency.

Name of Alternate Contact: _____Relationship to Child: _____

Contact's Phone Number: _____

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The following information will help the Healthcare Provider evaluate your child's health. Please answer to the best of your knowledge.

1. Is your child allergic to any medications? Yes____ No____ If yes, what? _____
_____

Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes____ No_____ If yes, what? _____

2. List any medications your child is taking now and reason for which the medication was given:

Medication/Dose	**Reason**	**How Long Taking Medication**
_____	_____	_____
_____	_____	_____
_____	_____	_____

3. Has your child had any serious or sports related injuries or been hospitalized overnight? Yes_____ No____ If yes, explain:_____
_____

4. Has there been any change in your child's health during the past year? Yes_____ No_____ If yes, give the age and describe the illness or injury:_____
_____

5. Has your child ever received mental health counseling services: Yes_____ No_____ If yes, when? _____
_____ With whom? _____

6. Please check if your child has ever had any of the following health problems and state at what age the problem started:

	Yes	Age		Yes	Age
Allergies	_____	_____	Pneumonia	_____	_____
Anemia or blood disorder	_____	_____	Rheumatic Fever/Heart Disease	_____	_____
Asthma	_____	_____	Scoliosis	_____	_____
Bladder or kidney infections	_____	_____	Seizures	_____	_____
Cancer	_____	_____	Severe Acne	_____	_____
Chicken Pox	_____	_____	Sports injuries or fractures	_____	_____
Diabetes	_____	_____	Thyroid Disease	_____	_____
Endocrine/Gland Disease	_____	_____	Tuberculosis	_____	_____
Hepatitis	_____	_____	Ulcer or digestive problems	_____	_____
Headaches/Migraines	_____	_____	Mental illness or depression	_____	_____
Mononucleosis	_____	_____	Other	_____	_____

7. I give North Valley School-Based Health Clinic consent to receive a copy of my child's immunizations records from School District #6 and/or Immtrax (Montana State Vaccine Database). _____Yes _____No – **Please initial**

8. Please check if you or any of your child's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems. Please state the relative's relationship to your child.

Condition	Yes	Relationship	Condition	Yes	Relationship
Alcoholism/Drugs	____	_____	High Cholesterol	____	_____

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Allergies/Asthma	____	_____	High Blood Pressure	____	_____
Arthritis	____	_____	Kidney Disease	____	_____
Birth Defects	____	_____	Lung Disease	____	_____
Blood Disorders	____	_____	Tuberculosis	____	_____
Sickle Cell Anemia	____	_____	Mental Health/Depression	____	_____
Cancer (type_____)	____	_____	Cognitive Impairment	____	_____
Diabetes	____	_____	Obesity	____	_____
Endocrine/Gland Disease	____	_____	Seizures/Epilepsy	____	_____
Heart Attack	____	_____	Stroke before Age 55	____	_____

9. How often does your child go to the dentist? At least once a year:_____ Only with toothaches:_____ Never:_____
   When was your child's last dental exam? _____

10. Are there smokers in your house? Yes:_____ No:_____

11. Does your child have a family doctor or pediatrician? Yes: _____ No: _____ If yes, please list your medical provider's name: _____. When did your child have his/her last *complete* physical exam? _____
    Please initial here if you would like your child to have a physical exam:
    _____My child has not had a physical exam within the last year. If time allows, I would like my child to have a physical exam during the school year.

12. Some parents or guardians have questions or concerns about their child's development. Please review the topics listed below and check any concerns you may have about <u>your</u> son or daughter:

Physical complaints	____	Violence	____
Physical development	____	School grades/truancy/dropout	____
Weight	____	Smoking cigarettes/chewing tobacco	____
Change of appetite	____	Drug use	____
Sleep patterns	____	Alcohol use	____
Diet/Nutrition	____	Dating/parties	____
Amount of physical activity	____	Sexual behaviors	____
Emotional development	____	HIV/AIDS	____
Relationships with family members	____	Birth Control	____
Choice of friends	____	Sexual identity (Heterosexual/homosexual)	____
Self-image/self-worth	____	Work or job	____
Excessive moodiness or rebellion	____	Lying, stealing or vandalism	____
Depression	____	Other: _____	____

13. Does your child have a current or chronic health condition? Yes____ No ____
    If yes, please explain: _____
    _____

14. Does your child have any special needs (physical handicap, learning disabilities, special dietary needs, etc.?)
    Yes____ No ____ If yes, please explain: _____
    _____

Indicate Pharmacy of Choice: _____

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CONSENT TO TREAT

The above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illnesses, prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child/myself. By signing below, I authorize my child/myself to be seen at the School-Based Health Clinic.

Your child's medical information will be treated with strict confidentiality in accordance with HIPAA and FERPA regulations. Please note the school nurse will be assisting the providers who staff the School-Based Health Clinic. Information obtained during the School-Based Health Clinic visit will be kept in the patient's medical record and is not accessible to school personnel. If you would like the School-Based Health Clinic to discuss your child's condition with school personnel, please contact North Valley Professional Center. Otherwise, it is your responsibility to notify the school of any medications, allergies, restrictions or medical problems that may affect your child during school.

All services will be provided in accordance with Montana state law. I agree to all the services listed on page one **except** what I have listed below.

I do not want my child to receive the following services: _____
_____
_____.

AUTHORIZATION, ASSIGNMENT AND GUARANTEE OF PAYMENT: I have provided complete and accurate demographic and insurance billing information allowing North Valley Professional Center and/or North Valley Behavioral Health to act as my billing agent for services rendered. I agree to "assign" to North Valley Professional Center and/or North Valley Behavioral Health all insurance benefits available for any professional and clinic services rendered, payable directly to North Valley Professional Center and/or North Valley Behavioral Health. I agree to promptly pay any and all charges regardless of the existence of insurance or other third party liability (within 30 days) of being billed, unless other arrangements have been made. Should my account be placed for outside collections, I agree to pay attorney fees reasonable with all costs and expenses incurred.

I understand this consent form will be valid for one year or until I provide the School-Based Health Clinic staff with written direction otherwise. I am the legal guardian of the above named child. I understand that a new consent form must be signed by the legal guardian if guardianship changes and if I am not this child's birth parent, I have attached a copy of proof of legal guardianship.

INSURANCE DISCLAIMER: It is my responsibility to obtain pre-authorization from my health insurance company. I understand I am liable for any charges incurred should my health insurance company deny any medical services. I certify I have read the foregoing and understand its contents. My questions have been answered to my satisfaction.

_____
Parent/Guardian Printed Name

_____ _____
Parent/Guardian Signature **Relationship of Child** **Date**

_____
Adult Patient Printed Name

_____ _____
Adult Patient Signature (self) **Date**