



Berger's Tiger Care Clinic

Located at: 100 Tiger Drive | Circleville, OH 43113 | Clinic Phone: 740-420-8354



Student Health Information

Student Name:		Date of Birth:	
Prefer To Be Called:		Social Security Number:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address:		City:	Zip:
Home Phone Number:	Cell Phone Number:	May we leave a message if necessary? <input type="checkbox"/> YES <input type="checkbox"/> NO	
Child's Physician Name and Number:		If your child should need a prescription, where should I send it to be filled (pharmacy):	

Emergency Contact Information (List in order you would like us to call if there were an emergency situation)

Name:	Phone Number:	Relation to Student:
Name:	Phone Number:	Relation to Student:
Name:	Phone Number:	Relation to Student:

Medical Information

1. Has your child ever had reaction to any of the following:
 No known allergies Latex (rubber gloves) Eggs Peanuts Bee stings Shellfish
 Medicines/Drugs (please describe) _____

2. Is your child taking any medicines/drugs (include non-prescription, herbs, fluoride, vitamins, or supplements) daily?
 YES NO
 If yes, please list: _____

3. Has your child had any of the following health problems or symptoms:

<input type="checkbox"/> Allergies (seasonal, hay fever, etc) <input type="checkbox"/> Asthma <input type="checkbox"/> Autoimmune disorder (lupus/juvenile arthritis /celiac disease) <input type="checkbox"/> Blood disorders (sickle cell/clotting problems) <input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes: (circle one) pre-diabetes, type 1, or type 2 <input type="checkbox"/> Heart problems (including murmur or high blood pressure) <input type="checkbox"/> High cholesterol <input type="checkbox"/> Broken bones: where? _____ <input type="checkbox"/> Stomach problems: Type _____	<input type="checkbox"/> Cavities or tooth pain/injuries <input type="checkbox"/> Missing or damaged organs (eye, kidney, testicle) <input type="checkbox"/> Many headaches/migraines <input type="checkbox"/> Head injury, concussion or seizures <input type="checkbox"/> Problems since birth (birth defect, down syndrome, autism, genetic disorder) Type: _____ <input type="checkbox"/> Developmental delay <input type="checkbox"/> Mental health condition (ADHD, anxiety, depression, etc.) <input type="checkbox"/> Other _____ _____ _____
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4. Has your child had any major injuries or been in the hospital overnight? YES NO
 If yes, what surgeries/injuries or why were they in the hospital? _____

Parent/Guardian Signature:	Date:
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Insurance Information:

Primary Insurance Company:

Address:

Insurance Holder's Name:

Date of Birth:

Group & ID #:

Social Security Number:

Employer:

Secondary Insurance Company:

No Secondary Insurance

Address:

Insurance Holder's Name:

Date of Birth:

Group & ID #:

Social Security Number:

Employer:

Consent to bill health insurance listed above for service provided in the Tiger Care Clinic.

No child will be denied care due to the inability to pay for services.

Student Name:

Date of Birth:

Parent/Guardian Name Printed:

Parent/Guardian Signature:

Today's Date: