OhioHealth 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: ☐ Male ☐ Female
Home Address:	City:	Zip:
Home Phone Number:	Cell Phone Number:	May we leave a message if necessary? ☐YES ☐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:
   - ❑ Allergies (seasonal, hay fever, etc)
   - ❑ Asthma
   - ❑ Autoimmune disorder (lupus/juvenile arthritis /celiac disease)
   - ❑ Blood disorders (sickle cell/clotting problems)
   - ❑ Cancer: Type_____
   - ❑ Diabetes: (circle one) pre-diabetes, type 1, or type 2
   - ❑ Heart problems (including murmur or high blood pressure)
   - ❑ High cholesterol
   - ❑ Broken bones: where? _____
   - ❑ Stomach problems:

   Type_____
   - ❑ Cavities or tooth pain/injuries
   - ❑ Missing or damaged organs (eye, kidney, testicle)
   - ❑ Many headaches/migraines
   - ❑ Head injury, concussion or seizures
   - ❑ Problems since birth (birth defect, down syndrome, autism, genetic disorder) Type: _____
   - ❑ Developmental delay
   - ❑ Mental health condition (ADHD, anxiety, depression, etc.)
   - ❑ Other_____

     _____

     _____

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:

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: