



**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
- Asthma
- Back Problems
- Blood clots
- Blood problems
- Blood transfusions
- Broken Bones
- Cancer
- Depression
- Problem with private parts (ovaries, vagina, uterus, testicles, penis)
- Other \_\_\_\_\_
- Diabetes
- Gall Bladder Disease
- Heart Problems
- Hepatitis/Liver Disease
- High Blood Pressure
- Intestinal Problems
- Kidney/Bladder Problem
- Learning Problems
- Severe Headaches
- Seizures
- Speech/Hearing Problems
- Stomach Problems
- Strokes
- Surgery/Operations
- Thyroid Problems
- Tuberculosis
- Vision Problems
- Weight Problems

**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 \_\_\_\_\_