

Student's name _____ Grade _____ ID number _____

Today's date _____ Male Female Date of birth _____

1. Do you have a regular doctor/provider? Yes No

2. MD/APN/Clinic: Name _____

Address _____

City _____

Phone _____ Fax _____

3. Do you have a regular dentist? Yes No

4. Dentist: Name _____

Address _____

City _____

Phone _____ Fax _____

5. Does your child see any other providers? Yes No
(Social worker, counselor, psychologist, psychiatrist, medical specialist, Other healer)

Name _____

Address _____

City _____

Phone _____ Fax _____

Name _____

Address _____

City _____

Phone _____ Fax _____