



APPLICATION FOR CLINIC APPOINTMENT

(This section to be completed by parent/guardian)

Student's Name _____ Birthdate _____
(Last) (First) (Middle)

Address _____ Apt # _____ Zip Code _____ Telephone _____ / _____

School _____ Grade _____ Room No. _____

(Financial Information Necessary for Vision Clinic Only)

*This appointment is requested because I am unable to pay for medical services and my child **does not have insurance that covers vision services.***

Length of residence in city _____ years. Number of adults at home _____. Number of children at home _____. Monthly income of father \$_____. Monthly income of mother \$_____. Other income \$_____. Total income \$_____.

An appointment date will be mailed to parent/guardian by the Nursing & Wellness Program.

I am willing to have my child examined, or treated, at the Nursing & Wellness Program Clinics.

Parent/Guardian's Signature Date

(This section to be completed by nurse)

(Student's Permanent ID#)

Please circle name of clinic desired: VISION HEARING

Immediate problem: _____

History and duration of problem: _____

Treatment to date, including surgery and any other treatments: _____

School progress (include any problems): _____

Has this child ever been seen in any of the school clinics before? _____ Date: _____

Health history (circle condition as pertains to this child): Heart Condition, Rheumatic Fever, Kidney Condition, Diabetes, Allergies, Asthma, Other _____ Medications _____

Complete if Referring for Vision Clinic

Visual acuity **without glasses**: R_____ L_____ Visual acuity **with glasses** (if applicable): R_____ L_____

Have glasses ever been worn? _____

Complete if Referring for Otology Clinic

Date of last known audiogram: _____

Please Mail Completed Form to:
Vision & Hearing Program, Wiggin, Rm. 14
Phone: (858) 627-7385; Fax: (858) 627-7384

Nurse's Signature Date