

Nimiipuu Health Medical History Form

Patient's Name <small>LAST FIRST MIDDLE INITIAL</small>		Nickname		Date of Birth	
Parent's/Guardian's Name			Relationship to Patient		Patient's Grade Level
Phone <small>Home Work</small>			Sex M F		
Have you (the parent/guardian) or the patient had any of the following diseases or problems?..... Y N 1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3. Cough that produces blood? If you answer yes to any of the three items above, please stop and return this form to the receptionist.					
Has the child had any history of, or conditions related to, any of the following: AnemiaY N Cancer.....Y N Earaches.....Y N HIV/AIDS.....Y N Mononucleosis.....Y N Thyroid.....Y N Cerebral Palsy.....Y N Fainting.....Y N Immunizations.....Y N Mumps.....Y N Tobacco/Drug Use.....Y N Asthma.....Y N Growth Problems..Y N Kidney.....Y N Pregnancy (teens)..Y N Tuberculosis..Y N Bladder.....Y N Sickle cell..Y N Hearing.....Y N Chicken Pox.....Y N Hepatitis.....Y N Arthritis.....Y N Chronic Sinusitis.....Y N Measles...Y N Latex allergy.....Y N Rheumatic Fever.Y N Bleeding disorders.Y N Diabetes.....Y N Heart.....Y N Sexually Transmitted Infection..Y N Liver.....Y N Seizures.....Y N Bones/Joints.....Y N Other_____					
Please list the name and phone number of the child's medical provider: Name of Provider_____ Phone _____					

Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? Y N

If yes, please list: _____

Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____ Y N

Is the child allergic to anything else, such as certain foods? If yes, please explain: _____ Y N

Has the child ever had a serious illness? If yes, when: _____ Please describe: _____ Y N

Has the child ever been hospitalized? If yes, when: _____ Please describe: _____ Y N

Does the child have a history of any other illnesses? If yes, please list: _____ Y N

Is the child physically, mentally, or emotionally impaired?..... Y N

Does the child experience excessive bleeding when cut?..... Y N

Has the child had any problem with dental treatment in the past? Y N

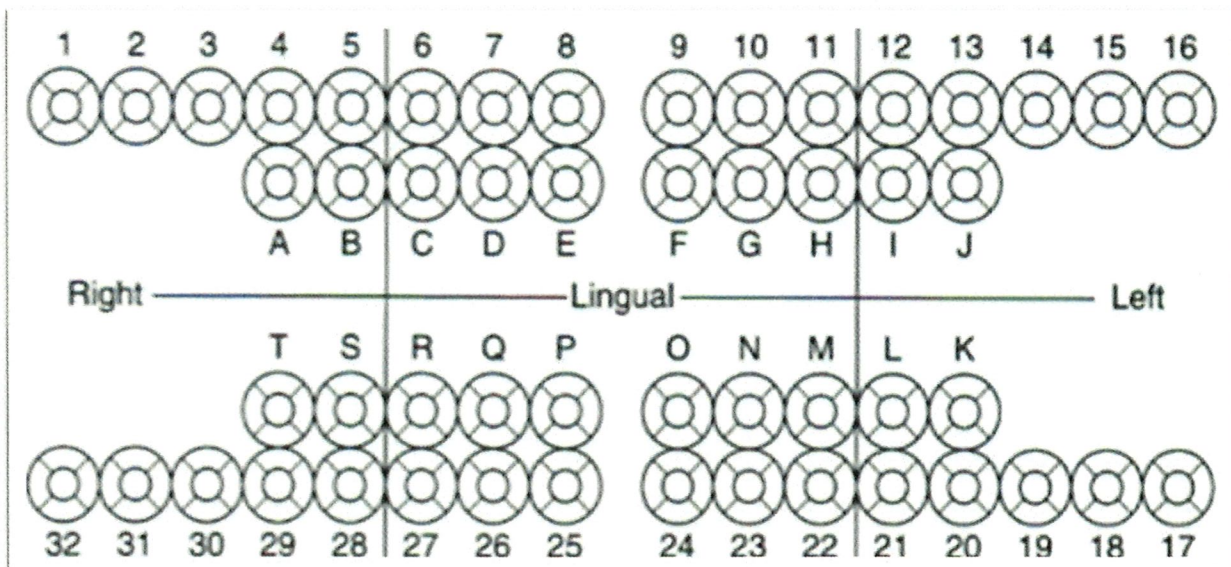
Has the child ever suffered any injuries to the mouth, head or teeth? Y N

Please provide Immunizations as needed for my child? Y N

The answers I have given are true to the best of my knowledge. I am indicating consent for routine procedures such as: immunizations ☐, sports physicals ☐, optical ☐, x-rays ☐, fluoride ☐, fillings ☐, and simple extractions of primary teeth ☐. Dental anesthetic (topical or local) is commonly used to provide comfort during dental care. It is safe but has certain risks. Common risks are bruising, swelling, or pain at the site of the injection. A temporary rapid heartbeat sometimes occurs. Permanent numbness or abnormal sensations rarely occur. I consent to the use of anesthetic for dental care ☐.

Parent's/Guardian's Signature _____ Date _____

Provider's Signature _____ Date _____



Media Release Form

Nimiipuu Health



I, _____, hereby grant permission to Nimiipuu Health and/or the United States National Guard, the rights of my image, in video or still, and the likeness and sound of my voice as recorded on audio or video. I understand that my image may be edited, copied, exhibited, published or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive the right to royalties or other compensation arising or related to the use of my image or recording. I also understand that this material may be used in diverse educational settings within an unrestricted geographic area.

Photographic, audio or video recordings may be used for ANY USE which may include but is not limited to:

- Presentations
- Courses
- Online/Internet Videos
- Media
- Social Media
- News (Press)

By signing this release, I understand this permission signifies that photographic or video recordings of me may be displayed via the Internet or in a public educational setting.

I will be consulted about the use of the photographs or video recording for any purpose other than those listed above.

There is no time limit on the validity of this release nor is there any geographic limitation on where these materials may be distributed for use in an any setting.

By signing this release, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material.

Full Name-Printed (Parent/Guardian if under 18): _____

Minor Full Name-Printed: _____

Phone Number and/or Email: _____

Email Address: _____

Signature (Parent/Guardian if under 18) _____ Date _____