

Project K.I.N.D.
APPOINTMENT/INTAKE INFORMATION

PK # _____

Name of Child _____ Age _____ Date _____
 DOB _____ M F Ethnicity _____ Primary Language _____
 Parents: Mother _____ Occupation _____
 Father _____ Occupation _____
 Guardian _____ Occupation _____
 Address: _____ City _____ Zip Code _____
 Telephone (home) _____ (work) _____
 Number of persons in the home _____ Are you a female head of household? _____
 Do you have health or medical insurance? (Medi-Cal, Healthy Families, or Healthy Kids) Yes _____ No _____
 School _____ Nurse _____
 Health Complaint _____

Please estimate the total gross annual income of all persons in your household from all sources of income:

1 person	2 persons	3 persons	4 persons	5 persons	6 persons	7 persons	8 persons
\$9,950	\$11,400	\$12,800	\$14,200	\$15,350	\$16,500	\$17,650	\$18,750
\$16,600	\$18,950	\$21,350	\$23,700	\$25,600	\$27,500	\$29,400	\$31,300
\$26,550	\$30,350	\$34,150	\$37,900	\$40,950	\$44,000	\$47,000	\$50,050

PARENT CONSENT/RELEASE

- I consent for a Project K.I.N.D. volunteer provider to provide evaluation and treatment of my child _____ and that he/she is seeing my child at no-cost for this one time only. I understand that he/she will not become my child's permanent physician and is providing this care on this date only. I will arrange for follow-up care for my child through a clinic facility or through arrangements with another healthcare provider at my own expense. I understand this program does not cover hospitalization or other medical expenses unless specifically agreed upon by Project K.I.N.D.
- I give my permission to release health information to the school health office and to Project K.I.N.D. This information will remain confidential and will be used only to improve and expand Project K.I.N.D. services to children.
- The recipient hereby agrees to indemnify and hold Riverside County Medical Association, Project K.I.N.D., and the School District, its Governing Board, the individual members thereof, and all officers, agents, and employees free and harmless from any loss, damage, liability, or cost of expense that may arise during or be caused by such treatment provided.
- I certify that the statements made on this form are true and I will contact Project K.I.N.D. if I need to cancel the appointment.
- A Project K.I.N.D. volunteer has my permission to transport my child and me to the appointment with prior arrangements.

Parent/Guardian Signature _____ Date _____
 Witness _____ Date _____

REFERRED FOR CARE TO THE FOLLOWING Project K.I.N.D. Provider

Name _____ Date _____ Time _____
 Address _____ Telephone() _____

Doctors donate their services. To cancel or reschedule an appointment please call (951) 686-3342.

TO BE COMPLETED BY ATTENDING HEALTHCARE PROVIDER

- Name of HealthCare Provider (please print) _____
- Findings/Diagnosis _____
- Recommendations _____

<u>Services Provided</u>	<u>Follow-up Needed</u>	<u>Future Treatment</u>
_____ Exam	_____ Lab	_____ Child needs to see a specialist
_____ Lab	_____ Pharmacy	_____ (specify what kind)
_____ Pharmacy	_____ Radiology	_____ I want to re-check child on
_____ Radiology	_____ Other (specify below)	_____ Date _____ Time
_____ Care Complete		_____ Re-check by someone else
		_____ Date

4) For our records, the normal fee for this visit(s) would total \$ _____

Health Care Provider Signature _____ Date _____

PROVIDER: PLEASE RETURN THIS FORM TO Project K.I.N.D.

COPY DISTRIBUTION:	RETURN FORMS TO:	
WHITE: Project K.I.N.D.	Project K.I.N.D.	If immediate follow-up is needed, Please call (951) 686-3342 Fax (951) 686-1692
YELLOW: HealthCare Provider	3993 Jurupa Avenue	
PINK: Parent/Guardian	Riverside, CA 92506	
DI/mw/forms/nursesforms/2004		