Mercyhealth™
A passion for making lives better.™

Today's Date _____

CARE MOBILE CONSENT FOR MEDICAL TREATMENT

- Fill in the blanks and then turn over this Consent form
- Read and sign on the other side of this form
- Complete the Pediatric Health History Form

Return the Consent For Medical Treatment form and the Pediatric Health History Form

Child's Name:			**Birth Date:**	**Age:**
Child's Sex: ☐ Male ☐ Female	**Primary Language** ☐ English ☐ Spanish ☐ Other: _____	**County:** ☐ Boone ☐ Stephenson ☐ Lee ☐ Winnebago ☐ Ogle ☐ Rock	**Race:** _Caucasion _Asian _African American _Hispanic _Indian _Other_____	
Person completing this form, write in your: Name:			Relationship to this Child:	
Name of Legal Guardian			Guardian Birthdate:	
Address of Legal Guardian, incl ZIP			Phone Number:	
Does the child have a Dentist? ☐ Yes ☐ No	**If Yes:** Name of the Dentist is:			
Does the child have a Doctor? ☐ Yes ☐ No	**If Yes:** Name of the Doctor is:			

Can we text you? Yes No

Would you like your child to start the HPV Series?
☐YES ☐NO

Would you like your child to receive the flu vaccine if available?
☐ YES ☐NO

Why do you want your child to be seen on the Care Mobile? _____

Does this child receive any of these benefits? **Check all benefits that this child receives.**

☐ Underinsured ☐ Medicaid ☐ No Insurance

If you have insurance but it will not cover physicals or vaccinations then you are underinsured. If you have a primary care doctor and have full medical coverage you need to see your primary care provider. ***

Turn over this form and read the other side
Sign on the other side of this form so this child can receive care from the Care Mobile

PLEASE read these explanations before signing and giving permission for this child to be seen by the Care Mobile staff:

1. The Care Mobile will be at a location for only 1 or 2 weeks at a time. Because of this the Care Mobile CANNOT assume the responsibility to complete the care for this child or to provide ongoing care for this child.

2. If the Care Mobile begins treatment for this child and cannot complete the care within the time at your location, it is your responsibility to make other arrangements for the care of this child.

3. When the Care Mobile is at your location the staff will try to help you find a local caregiver, but we cannot guarantee those arrangements can be made.

4. IF arrangements cannot be made for follow-up care, you may ask for a copy of the Care Mobile schedule to make an appointment at a different location and transport this child to that location.

5. PLEASE answer all questions on the Pediatric Health History form completely and accurately. The answers you put on that form will help us give the best medical and dental care for this child in a safe way. Incorrect information may be dangerous to this child's health.

    - PLEASE -- if you do not understand a question – if you are not sure of the answer – if you want to talk about a question with the Care Mobile staff, put a note with the Pediatric Health History form when you return the form

    - The Pediatric Health History form becomes part of this child's record with the Care Mobile and is kept totally confidential

MEDICAL CARE CONSENT

☐ I give my consent for the Doctor and/or the Nurse Practitioner to provide, as needed, the following medical services for this child.

- Physical examination
- Laboratory work
- Permission to contact this child's primary care doctor about referrals or consultations
- Required vaccines-routinely done at these visits if needed, other vaccines may be needed:
    - Kindergarten: DTap-IPV and MMRV
    - 6th grade: TDaP, MCV-4, HPV
    - 12th grade: MCV-4

I UNDERSTAND and CONSENT

☐ I have read and understand this Consent Form.

☐ My questions have been answered in a satisfactory manner.

☐ I understand I have the right to receive answers to questions that may come up during this child's treatment.

☐ I understand there are no guarantees about any treatment results.

☐ **I understand I am free to withdraw my consent to treatment at any time**

☐ **I understand this Consent for Medical / Dental Treatment shall remain in effect until I choose to end it.**

_____ _____

Signature of Parent or Legal Guardian Date Signed

The Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, INC. (RMHC), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

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Student Name _____

Date of birth _____

Today's Date _____

Parents please complete this form so we can treat your child or children.
TB/Cholesterol Risk Assessment/ Immunization Questions

TB Risk Factors- Please circle Yes or NO

1. Has your child been in contact with anyone who has tuberculosis? YES NO
2. Has your child ever had a positive tuberculosis test? YES NO
3. Has your child had close contact with anyone that has testing positive? YES NO
4. Was your child born outside the United States? YES NO
5. Has anyone in your family recently migrated from another country? YES NO
6. Has anyone in your immediate family traveled outside of the USA? YES NO
7. Has your child had contact with anyone with HIV, or in jail? YES NO
8. Has your child or other family members lived in a shelter? YES NO

Cholesterol Risk Factors

1. Does either of the parents have high cholesterol levels? YES NO
2. Has any member of the family had a heart attack or stroke before age 55? YES NO

Immunization Questions- Please answer yes/no/ don't know

1. Is the child sick today? YES NO
2. Does the child have allergies to medications, foods, or any vaccine? YES NO
3. Has the child had a serious reaction to a vaccine in the past? YES NO

Has the child had a health problem with

Asthma YES NO
Lung disease YES NO
Heart disease YES NO
Kidney disease YES NO
Diabetes YES NO
Blood disorder YES NO
Seizures YES NO
Cancer, leukemia YES NO
AIDS, immune problems YES NO

Has the child taken cortisone, prednisone, or other steroids? YES NO
Has the child had x-ray taken within the last 3 months? YES NO
Has the child had a blood transfusion or blood products, or medicine related? YES NO
Is the child pregnant or a chance she could become pregnant during the next month? YES NO
Has the child received vaccinations in the past 4 weeks? YES NO
Do you have a current immunization record with you today? YES NO

Parent Signature _____

Please print your full name _____

Pediatric Health History Form
Ronald McDonald Care Mobile

Childs Name_____

Date of Birth_____

Today's Date_____

A. We are required to ask the following questions in order to be able to know that you understand the information we give you. Check the correct answer.

Do you have any condition that makes it difficult for you to understand information?
_____Yes _____No
_____Hearing _____Seeing
_____Hard to remember _____Reading

Language spoke at home_____

1. Would you like any special cultural or religious considerations addressed in your care today? _____Yes _____No
2. Is anyone in your family in a relationship where they feel threatened or afraid of being hurt? _____Yes _____No
3. If you are unable to be home what arrangements are made?

_____
_

B. Pregnancy and Birth

1. Mothers age at birth _____
2. Did mother have any illness during pregnancy? _____Yes _____No
3. Take any medications other than vitamins and iron? _____Yes _____No

   Use Tobacco? _____
   Use Alcohol? _____
   Use Recreational Drugs? _____

4. Was the baby preterm ____Yes ____No
5. Delivery _____Vaginal _____C-Section
6. What was the birth weight?_____
7. Did the baby have any trouble while in the hospital such as respiratory, jaundice, infections? _____
8. Any other complications in pregnancy or birth? _____
   _____

C. Past Medical History

1. Record of Immunizations ____Yes _____No
2. Reactions to any immunizations ___Yes _____No
   _____
3. Allergic reactions to any medications ____Yes ___No
4. Allergic reactions to any foods _____Yes _____No
5. Allergic reactions to any insect bites _____Yes ____No
   Please explain
   _____
6. Where has your child gone for checkups until now?
   _____
7. Last Medical check up _____
8. Last Dental check up _____
9. Hospitalizations _____Yes _____No
10. For What? _____
11. Any serious injuries? _____
    What Kind _____
12. List Medications taken regularly
    _____

    _____

D. Feeding and Nutrition

1. Childs appetite? _____
2. Breast Fed_____ How Long_____
3. Vitamins _____Yes _____No
4. Severe Colic _____Yes _____No
   Unusual colic _____Yes _____No
5. Do any foods disagree with child

   _____Yes _____No

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E. Review of Symptoms

Please mark if the child has had problems with the following:

_____Frequent ear infections
_____Eye problems
_____Frequent colds or sore throat
_____Pneumonia, Asthma, breathing issues
_____Heart murmur or heart problems
_____Urination, diarrhea, constipation
_____Convulsions, Hives, Eczema
_____Other

Please list any other medical problems.

_____

_____

F. Development / Behavior

1. Age child could sit alone?_____
2. Age child walked? _____
3. Age started talking?_____
4. How does this child compare to others that same age?_____
5. School name?_____
6. Does child have problems getting along with other children? _____
7. Please mark if your child has had any of the following ;

_____Problems with discipline
_____Trouble sleeping, nightmares
_____Nail biting, thumb sucking
_____School troubles
_____Bad Temper
_____Hyperactivity
_____Problems with toilet training

Other_____
_____

How is your child disciplined?

_____

Has sex education been discussed _____

Date of first menstrual period

G. Safety / Environment

1. Do you live in a
   _____Apartment _____Home
   _____Other
2. Is the hottest temperature of the water below 120F?
   _____
3. Is there a working smoke alarm on each floor of your home? _____
4. Are there any smokers in the family?
   _____
5. Are there any problems with peeling paint, insects, or rodents?_____
6. If there are firearms in your home are they secured?
   _____
7. Does your child always use a car seat or seatbelt when riding in the car? _____
8. Does your child always wear a helmet when riding a bicycle or rollerblading? _____

H. Family History:

1. Does either parent have any health problems?

_____

2. Have you had any children die _____
3. Please mark any diseases that this child parents, grandparents, brothers, sisters, aunts or uncles have had?

____Anemia	_____Sickle Cell
____Asthma	_____Tuberculosis
____Allergies	_____Diabetes
____High Blood Pressure	_____Heart Trouble
____Mental Illness	_____Drug problems
____Alcohol Problems	_____Cancer
____Venereal Disease	_____AIDS

____Other _____
_____

Please list name and ages of siblings, and general health

Name Age/Sex healthy

_____
_____
_____
_____
_____
_____
_____