



The State of Illinois and OCUSD #220 require all medical documents be turned in by October 15<sup>th</sup> or Your student will be excluded from school. If your child has Kid Care, does not have medical Insurance or their insurance doesn't pay for physicals and or immunizations, you can schedule an appointment for the Ronald McDonald Care Mobile.

**The Ronald McDonald Care Mobile will be at the school on October 9<sup>th</sup>, 10<sup>th</sup>**  
**If your student still needs the medical requirements listed below,**  
**please call and schedule an appointment.**

**Physicals and Immunizations- Pre-K, Kindergarten, 6<sup>th</sup> grade, 9<sup>th</sup> grade and all new Students to the district.**

**Immunization only – 12<sup>th</sup> grade**

**Call and schedule your appointment today**

The Care Mobile provides **free medical care to uninsured or underinsured** children ages 0 to 18 years.

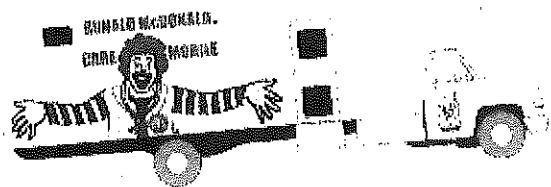
**Medical visits will be available by**  
**Appointment: please contact Sharon Hoover**  
**815-732-5300 ext 2222**

**Consent forms available on the district web site home page**  
**or can be picked up in the school office.**

**This is a FREE and CONFIDENTIAL service.**

Some of the services provided are immunizations, physicals, well-child exams, and sports physicals

For more information about the Care Mobile, call (815)971-5810.





## CARE MOBILE CONSENT FOR MEDICAL / DENTAL 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 / Dental Treatment form and the Pediatric Health History Form**

Child's Name:		Birth Date:		Age:	
Child's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	County: <input type="checkbox"/> Boone <input type="checkbox"/> Stephenson <input type="checkbox"/> Lee <input type="checkbox"/> Winnebago <input type="checkbox"/> Ogle	Race: _Caucasion    _Asian _African American    _Hispanic _Indian    _Other_____		
Person completing this form, write in your:			Relationship to this Child:		
Name:			Phone Number:		
Name of Legal Guardian			Home Phone:		
Address of Legal Guardian, incl ZIP					
Does the child have a Dentist? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Name of the Dentist is:				
Does the child have a Doctor? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Name of the Doctor is:				
<b>Can we text you?   Yes   No</b>					
Does this child receive any of these benefits?      Check all benefits that this child receives.					
<input type="checkbox"/> Underinsured <input type="checkbox"/> Medicaid <input type="checkbox"/> 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 please see your primary care provlder.					

**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
    - 6<sup>th</sup> grade: TDaP, MCV-4, HPV
    - 12<sup>th</sup> grade: MCV-4

**DENTAL CARE CONSENT**

- I give my consent for a dental exam and treatment that may include x-rays, fluoride application, sealants, cleaning, topical anesthesia, local anesthesia, fillings for this child's teeth, and to take a photograph of this child's mouth.

**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.
- I have been offered a copy of Rockford Health System's Joint Privacy Notice.

\_\_\_\_\_  
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.

**PEDIATRIC HEALTH HISTORY**  
(To be filled out by parent)

NAME _____	
CLINIC # _____	LABEL _____
DATE OF BIRTH _____	

TODAY'S DATE \_\_\_\_\_

PARENT/GUARDIAN - NAME - AGE - OCCUPATION \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If adults in household work outside the home, what child care arrangements are there for this child?  
 \_\_\_\_\_  
 \_\_\_\_\_

**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 spoken in home \_\_\_\_\_  
 1. Would you like any special cultural or religious considerations addressed in your teaching or care?  Yes  No  
 Please explain \_\_\_\_\_

2. Is anyone in your family in a relationship where they feel threatened or afraid of being hurt?  
 Yes  No

When you are receiving instructions or education if you would like someone else present to hear the information, please let us know.

**B. PREGNANCY AND BIRTH:**  
 1. Mother's 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  
 Alcohol  
 Recreational Drugs

4. Was the baby pre-term?  Yes  No \_\_\_\_\_  
 \_\_\_\_\_  
 5. Delivery?  Vaginal  C-Section  
 6. What was the birth weight? \_\_\_\_\_  
 Discharge weight? \_\_\_\_\_  
 Birth length? \_\_\_\_\_  
 7. Did the baby have any trouble while in the hospital such as respiratory, jaundice, infections, other?  Yes  No  
 What kind? \_\_\_\_\_  
 8. Any other complications in pregnancy or birth?  
 Yes  No

**C. PAST MEDICAL HISTORY:**  
 1. Record of immunizations?  Yes  No  
 2. Reactions to any immunizations?  Yes  No  
 3. Allergic reactions to any medications, foods, or insect bites?  Yes  No  
 Explain \_\_\_\_\_  
 4. Where has your child gone for check-ups until now? \_\_\_\_\_  
 5. Last check up \_\_\_\_\_  
 6. Last dental check-up \_\_\_\_\_  
 7. Hospitalizations?  Yes  No  
 For what? \_\_\_\_\_  
 8. Any serious injuries  Yes  No  
 What kind? \_\_\_\_\_  
 9. List medications taken regularly  

Medication/Herbal Prod	Dose	Freq.
_____	_____	_____
_____	_____	_____

**D. FEEDING AND NUTRITION:**  
 1. Child's appetite?  Good  Poor  
 2.  Breast Fed? How Long? \_\_\_\_\_  
 Formula & Brand? \_\_\_\_\_  
 3. Vitamins?  Yes  No  
 Type \_\_\_\_\_  
 4. Severe colic?  Yes  No  
 Unusual feeding problem?  Yes  No  
 5. Do any foods disagree with child?  Yes  No

**PEDIATRIC HEALTH HISTORY (continued)**

NAME _____	
CLINIC# _____	LABEL _____
DATE OF BIRTH _____	

**E. REVIEW OF SYSTEMS:**

Check if child has had problems with the following:

- Frequent ear infections
- Eye problems
- Frequent colds or sore throat
- Recurrent coughs
- Pneumonia
- Heart murmur
- Problems with urination
- Diarrhea
- Convulsions
- Hives
- Other skin conditions
- Teeth problems
- Asthma
- Heart problems
- Constipation
- Eczema
- Anemia

Please list any other medical problems. \_\_\_\_\_

**F. DEVELOPMENT/BEHAVIOR:**

1. Age child could sit alone? \_\_\_\_\_
2. Age child walked alone? \_\_\_\_\_
3. Age started talking? \_\_\_\_\_
4. How does this child compare to others the same age? \_\_\_\_\_
5. School name \_\_\_\_\_  
Grade \_\_\_\_\_
6. Does child have problems getting along with other children?  Yes  No
7. Check if your child has had any of the following:
  - Problems with discipline
  - Trouble Sleeping
  - Thumb sucking
  - Bad temper
  - Nightmares
  - Problems with toilet training
  - Other \_\_\_\_\_
  - School Trouble
  - Nail biting
  - Hyperactivity
  - Speech problems
8. How is your child disciplined? \_\_\_\_\_
9. Has sex education been discussed in
  - School
  - Home
  - Church
  - Other \_\_\_\_\_
10. Date of first menstrual period \_\_\_\_\_

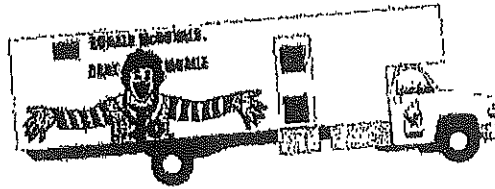
**G. SAFETY / ENVIRONMENT:**

1. Do you live in a
  - Private house
  - Apartment
  - Other \_\_\_\_\_
  - Mobile home
2. Is the hottest temperature of the water below 120° F?  Yes  No
3. Is there a working smoke alarm on each floor in the home?  Yes  No
4. Are there any smokers in the home?  Yes  No
5. Are there any problems with the condition of your home? (peeling paint, insects, rats/mice)  Yes  No
6. If there are firearms present in your home, are they locked?  Yes  No
7. Does your child always use a car seat/seat belt when riding in the car?  Yes  No
8. Does your child always wear a helmet when riding a bicycle or rollerblading?  Yes  No

**H. FAMILY HISTORY:**

1. Do either of the parents have a health problem?  No  Yes \_\_\_\_\_
2. Have you had children die?  No  Yes \_\_\_\_\_
3. Check any diseases that this child's parents, grandparents, brothers, sisters, aunts, or uncles have had:
  - Anemia
  - Asthma
  - Allergies
  - High Blood Pressure
  - Heart Trouble
  - Mental Illness
  - Alcohol Problems
  - Venereal Disease
  - Other \_\_\_\_\_
  - Sickle Cell
  - Tuberculosis
  - Diabetes
  - Drug problems
  - Cancer
  - AIDS
4. List name, age, sex, and general health of patient's brothers and/or sisters.
 

Name	Age/Sex	General Health
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**TB/ Cholesterol Risk Assessment**

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_ Date \_\_\_\_\_

**TB Risk Factors**

- |  |     |    |
|--|-----|----|
| 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 tested 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 the United States? | 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**

- |  |     |    |
|--|-----|----|
| 9. Does either of the parents have a cholesterol level over 240?             | YES | NO |
| 10. Has any member of the family had a heart attack or stroke before age 55? | YES | NO |

Person filling out this form: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

**Renewal Signatures:**

Date: \_\_\_\_\_ No Change/ Yes, item Number: \_\_\_\_\_

Date: \_\_\_\_\_ No Change/ Yes, item Number: \_\_\_\_\_

Date: \_\_\_\_\_ No Change/ Yes, item Number: \_\_\_\_\_

Date: \_\_\_\_\_ No Change/ Yes, item Number: \_\_\_\_\_

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (mo.) (day) (yr.)

## Screening Questionnaire for Child and Teen Immunization



**For parents/guardians:** The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't Know
1. Is the child sick today?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the child have allergies to medications, food, or any vaccine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the child had a serious reaction to a vaccine in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the child had a health problem with asthma, lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), or a blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the child had a seizure, brain, or nerve problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Has the child received a transfusion of blood or blood products, or been given a medicine called immune (gamma) globulin in the past year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Has the child received vaccinations in the past 4 weeks?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**Did you bring your child's immunization record card with you?**      yes  no

It is important to have a personal record of your child's vaccinations. If you don't have a personal record, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep this record in a safe place and bring it with you every time you seek medical care for your child. Your child will need this important document for the rest of his or her life to enter day care or school, for employment, or for international travel.