ROCKFORD HEALTH system

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:	Primary Language	County:	Race:
☐ Male ☐ Female	☐ English ☐ Spanish ☐ Other:	☐ Boone ☐ Stephenson ☐ Lee ☐ Winnebago ☐ Ogle	_Caucasion _Asian _African American _Hispanic _Indian _Other_________

Person completing this form, write in your: Name:	Relationship to this Child:
Name of Legal Guardian	Phone Number:
Address of Legal Guardian, incl ZIP	Home Phone:
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

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 please 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

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.

ROCKFORD HEALTH PHYSICIANS

Respectful Care

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

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 ☐ School Trouble
   - ☐ Thumb sucking ☐ Nail biting
   - ☐ Bad temper ☐ Hyperactivity
   - ☐ Nightmares ☐ Speech problems
   - ☐ Problems with toilet training
   - ☐ Other ______
8. How is your child disciplined? ______
   ______
   ______
   ______
9. Has sex education been discussed in
   ☐School ☐Home ☐Church
   ☐Other______
10. Date of first menstrual period ______

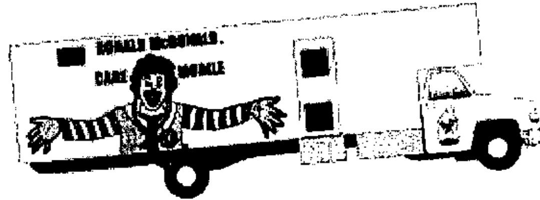
G. SAFETY / ENVIRONMENT:

1. Do you live in a ☐ Private house ☐ Apartment ☐ Mobile home ☐ Other ______
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 ☐ Sickle Cell
   - ☐ Asthma ☐ Tuberculosis
   - ☐ Allergies ☐ Diabetes
   - ☐ High Blood Pressure
   - ☐ Heart Trouble
   - ☐ Mental Illness ☐ Drug problems
   - ☐ Alcohol Problems ☐ Cancer
   - ☐ Venereal Disease ☐ AIDS
   - ☐ Other______
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 turberculosis? YES NO

2. Has your child ever had a positive tuberculosis test? YES NO

3. Has your child had close contact with anythat that has testing postive? 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 outsider 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?	☐	☐	☐
2. Does the child have allergies to medications, food, or any vaccine?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
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?	☐	☐	☐
5. Has the child had a seizure, brain, or nerve problem?	☐	☐	☐
6. Does the child have cancer, leukemia, AIDS, or any other immune system problem?	☐	☐	☐
7. Has the child taken cortisone, prednisone, other steroids, or anticancer drugs, or had x-ray treatments in the past 3 months?	☐	☐	☐
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?	☐	☐	☐
9. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
10. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

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.

Technical content reviewed by the Centers for Disease Control and Prevention, August 2007

Immunization Action Coalition • 1573 Selby Ave. • St. Paul, MN 55104 • (651) 647-9009 • www.immunize.org • www.vaccineinformation.org