Ronald McDonald Children's Hospital of Loyola University Medical Center
MOBILE MEDICAL UNIT VISIT CONSENT/REGISTRATION FORM
******All information must be completed in order for your child to be seen******

Child's Name: ____________________________ Date of Birth: ___/___/___ Sex: M____ F____
Child's Social Security No: __________________ Address: ____
City ________________ Zip Code ____________ Phone Numbers: _______________________ _________________________
Mother's Name: ___________________________ Father's Name: _____________________________

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1) Family Doctor? Yes__ No __ Name of Doctor: ___________________ Location: ___________________________________
2) Last Visit: ________________ Reason: ____
3) Has child missed any school because the physical/immunizations have not been done? Yes ___ No ___
If yes, how many school days have been missed? _______
4) Known health problems and/or illnesses being treated (list): ____
5) Any history of cancer, leukemia, HIV or immunodeficiency? Yes ___ No ___ If yes, please list: ______________
6) Taking any medication (list): ____
7) Any allergies (list): ____
8) Any specific allergy to neomycin, streptomycin, gelatin, baker's yeast or eggs? Yes___ No ____
9) Any reaction to previous vaccinations especially seizure, fever (105 or above), anaphylaxis, rash or change in mental state? Yes ___ No ___, If yes, please explain: ____
10) For teenage girls being seen, could you be pregnant? Yes ___ No ___
11) How many times has your child been to the Emergency Room this last year? ____
Reasons (list): ____
12) Family History of child being seen (**M**=Mom**, F**=Father, **S**= Sister, **B**=Brother, **G**=Grandparent, **A**=Aunt, **U**=Uncle)
Place the initial **M, F, S, B, G, A, U** for each family member affected with each condition listed below:

Heart Disease: ______ Cancer: ______ High Cholestrol: ______ Asthma: ______ Diabetes: ______ High Blood Pressure: ______
Growth Problem: ______ Seizures: ______ Other: ______

PHYSICAL EXAM CONSENT:

I GIVE THE STAFF OF THE RONALD McDONALD CHILDREN'S HOSPITAL OF LOYOLA UNIVERSITY MEDICAL CENTER'S MOBILE MEDICAL UNIT PERMISSION TO PERFORM A PHYSICAL EXAM OF MY CHILD IDENTIFIED ABOVE.

Signature: ____ Print Name: ____
Relationship to child: Mother ___ Father ____ Legal Guardian ___ Dated: _____________________________________

IMMUNIZATION CONSENT:

Immunizations required: (school nurse or mobile medical unit staff will circle all that apply):

Polio (IPV)	Mumps, Measles, Rubella (MMR)	Diptheria, tetanus, pertussis (DTP)	Hepatitis B	Tetanus, Diptheria (TD)	Haemophilus Influenza (Hib)

I have read or have had explained to me information about the immunizations identified above. I hereby acknowledge that I have been informed of the risks and benefits and I have had the chance to ask questions that were answered to my satisfaction. I understand the risks of the above vaccines and ask that the vaccines be given to the child named above for whom I am authorized to make this request.

Signature: ____ Print Name: ____
Relationship to child: Mother ___ Father ____ Legal Guardian ____ Dated: _______________________________________

CONSENT FOR RELEASE OF HEALTH INFORMATION:

The undersigned hereby authorizes and requests LUHS, LUMC and the Staff of the Ronald McDonald Children's Hospital to disclose and release health information pertaining to the physical exam of the child named above to the following:

Name/address of person/facility to be released to: ____
Purpose for which you want this information released: ____
This authorization is valid until _________________. This consent for release of information may be revoked at any time except that such revocation will not apply to any uses and disclosures of your child's information that are described in the LUHS Notice of Privacy Practices or otherwise allowable under Federal and State laws. I hereby acknowledge that I understand the information contained in the above Consent for Release of Health Information.

Signature: ____ Print Name: ____
Relationship to child: Mother ___ Father ____ Legal Guardian ____ Dated: _______________________________________

I acknowledge receipt of a copy of the Notice of Privacy Practices. (please check) ________