CHICAGOLAND & NORTHWEST INDIANA

Advocate Children's Hospital

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Ronald McDonald Care Mobile

1675 W. Dempster ~ Park Ridge, IL 60068
Phone 847-723-7358 ~ Fax 847-723-9566

4440 W. 95th Street ~ Oak Lawn, IL 60453
Phone 847-723-7358 ~ Fax 708-684-4763

Dear Parent/Guardian:

The Advocate Children's Hospital Ronald McDonald Care Mobile is scheduled for _____ on _____.

Our mission is to offer easy access to quality health care (health screenings, school or sports physicals and immunizations) for your child; we work with schools and community groups to provide free services at schools and community centers.

To provide the best and safest care for your child we need the forms in this packet completed, including all signatures. Packet includes:

- Patient Information Sheet which includes consent for treatment
- Child history form and/or sports history form
- Vaccine (shot) records (if not provided by the school)
- Insurance information if applicable (Medicaid plan name and ID number)

Your consent for treatment will allow us to immunize your child according to CDC and IDPH guidelines. Please view the following website for information on the vaccine schedule and Vaccine Information Sheets for each immunization: http://www.cdc.gov/vaccines/hcp/vis/current-vis.html

We encourage parent/guardian participation in the child's visit, so please include a phone number where we may reach you during school hours.

To fully care for your child, we look at the many needs of each child and family. When possible, we provide support to meet those needs. We will also assist you with referrals for ongoing health care and application information for state-funded health insurance if desired.

All services are provided at no cost for students without insurance or with Medicaid (state-funded insurance) but we cannot accept students with private insurance.

We look forward to providing your child with the best health care possible!

The Advocate Children's Hospital Ronald McDonald Care Mobile Staff

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Patient Demographic Information and Patient Agreements & Authorizations Form

General Patient Information:

Child's Full Name	Child's Date of Birth Child's Age	Child's Sex □ Male □ Female
Child's Address	City/State	Zip Code
Child's School Child's Grade	Child's Race (mark all that apply) □ African-American □ Caucasian □ Asian □ Hispanic □ Other _____	Child's Preferred Language
Parent/Legal Guardian's Full Name	Best Daytime Contact Number	

Doctor/Insurance Information

Child's **Regular/Primary doctor**	Doctor's Address	Doctor's Phone Number
Which type of insurance does your child have (please circle)? Medicaid/Public Insurance No Insurance Private Insurance (PPO/HMO)		Doctor's Fax Number □ child does NOT have a PCP

Immunization Information

Please list any REQUIRED immunizations you do NOT want your child to receive

Please mark which RECOMMENDED immunizations you do or do not want you child to receive

Flu vaccine □ Yes □ No
Hepatitis A Vaccine (2 dose series) □ Yes □ No
HPV (Human Papilloma Virus) vaccine □ Yes □ No
(2 does series if 11-15, 3 dose series if 15 or older)

May your child receive free healthy snack items (may contain nuts, soy, dairy, egg or gluten)? □ Yes □ No

CONSENT FOR TREATMENT: I do consent/permit to the treatment provided by Advocate Physicians, Nurses or other designated health care providers. I understand that Physicians, Nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my child's treatment and I consent/permit to such student involvement. This treatment can include physical examination, health screenings and all recommended and required immunizations except where declined above.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

- I authorize/allow the use and disclosure of this personal health information (PHI) for the purposes of diagnosing or providing treatment to my child, obtaining payment for care, or for health care business management of Advocate Medical Group.
- I authorize/allow Advocate to release information required in the process of applications for financial coverage for services. This authorization provides that Advocate may release specific clinical information related to my child's diagnoses and treatment, which may be requested by an insurance company or its representative.
- I authorize Advocate to provide my child's educational institution/school with a copy of the health exam and to include immunizations administered.
- I authorize Advocate to release information from the visit to the primary health care provider/doctor provided above.

DISCLAIMER: This 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.

Patient's Parent/Guardian: _____ **Date:** _____

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Child History Form

*****Please complete as much information as possible for us to best care for your child*****

Child's Name	Date of Birth
Last visit to regular doctor	Reason
Last visit to dentist	Last vision test

How many days has the child missed from school in the past year? _____ Reason(s)_____
Were any because the required physical or immunizations were not complete? ☐ Yes ☐ No

Has the child been in the Emergency Room in the past year? ☐ Yes ☐ No
If yes, please list reasons: _____

Has the child had any overnight hospitalizations or any surgeries? ☐ Yes ☐ No If yes, please list: _____

Please list the child's medications: _____

Please list allergies to any medication/foods/other: _____

Has the child had any reaction to previous immunizations: (please circle)
NONE fever (104 or more) seizure severe allergic reaction rash change in mental status

Does the child have any health problems or major illnesses below?

Asthma	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Birth defects	☐ Yes ☐ No	Heart problem (heart murmur, high blood pressure)	☐ Yes ☐ No
Ear infections	☐ Yes ☐ No	Constipation	☐ Yes ☐ No
Sickle cell/hemophilia	☐ Yes ☐ No	Dizziness or chest pain with exercise	☐ Yes ☐ No
Bone/joint problems	☐ Yes ☐ No	Ear/hearing problems	☐ Yes ☐ No
Developmental delay	☐ Yes ☐ No	Eye or vision problems, wears glasses or contacts	☐ Yes ☐ No
Behavioral concerns	☐ Yes ☐ No	Other (please list):	

Child's Family History: Place the letter of family member who has each problem on chart below—Mother, Father, Sister, Brother, Grandparent

Heart disease	Asthma	High blood pressure	Cancer
Stroke	Seizures	Diabetes	Sudden death before age 50

Please mark yes or no for the following statements:

☐ Yes ☐ No In the past 12 months, our family has run out of food before we had money to buy more
☐ Yes ☐ No In the past 12 months, our family has worried we would not have enough food before we had money to buy more
☐ Yes ☐ No The child is exposed to cigarette smoke in the home
☐ Yes ☐ No There is a gun in the home where the child lives or spends a lot of time
☐ Yes ☐ No The child wears a seat belt in the car
☐ Yes ☐ No The child owns a bike helmet
☐ Yes ☐ No The child is in need of mental health/behavioral health resources

Please list anything else you would like us to know about the child or any special concerns?
_____

Printed name	**Date:**
Parent/legal guardian signature	

State of Illinois
Certificate of Child Health Examination

Student's Name Last First Middle	Birth Date Month/Day/Year	Sex	Race/Ethnicity	School /Grade Level/ID#
Address Street City Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric DT (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps. Rubella				Comments: * indicates invalid dose		
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT NOT REQUIRED Vaccine / Dose						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered/Dates						

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.
Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date Month/Day/ Year	Sex	School	Grade Level/ ID

HEALTH HISTORY TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:

MEDICATION (Prescribed or taken on a regular basis.)	Yes / No	List:

Diagnosis of asthma?	Yes No		
Child wakes during night coughing?	Yes No		
Birth defects?	Yes No		
Developmental delay?	Yes No		
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes No		
Diabetes?	Yes No		
Head injury/Concussion/Passed out?	Yes No		
Seizures? What are they like?	Yes No		
Heart problem/Shortness of breath?	Yes No		
Heart murmur/High blood pressure?	Yes No		
Dizziness or chest pain with exercise?	Yes No		
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____ Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)			
Ear/Hearing problems?	Yes No		
Bone/Joint problem/injury/scoliosis?	Yes No		

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes No		
Hospitalizations? When? What for?	Yes No		
Surgery? (List all.) When? What for?	Yes No		
Serious injury or illness?	Yes No		
TB skin test positive (past/present)?	Yes* No	*If yes, refer to local health department.	
TB disease (past or present)?	Yes* No		
Tobacco use (type, frequency)?	Yes No		
Alcohol/Drug use?	Yes No		
Family history of sudden death before age 50? (Cause?)	Yes No		
Dental ☐ Braces ☐ Bridge ☐ Plate Other			

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature Date

PHYSICAL EXAMINATION REQUIREMENTS Entire section below to be completed by MD/DO/APN/PA
HEAD CIRCUMFERENCE if < 2-3 years old HEIGHT WEIGHT BMI BMI PERCENTILE B/P

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) BMI>85% age/sex Yes☐ No☐ And any two of the following: Family History Yes ☐ No ☐
Ethnic Minority Yes☐ No ☐ Signs of Insulin Resistance (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ At Risk Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)
Questionnaire Administered? Yes ☐ No ☐ Blood Test Indicated? Yes ☐ No ☐ Blood Test Date Result

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm.
No test needed ☐ Test performed ☐ Skin Test: Date Read Result: Positive ☐ Negative ☐ mm_____
Blood Test: Date Reported Result: Positive ☐ Negative ☐ Value

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		☐ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ No ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in
PHYSICAL EDUCATION Yes ☐ No ☐ Modified ☐ (If No or Modified please attach explanation.) **INTERSCHOLASTIC SPORTS** Yes ☐ No ☐ Modified ☐

Print Name (MD,DO, APN, PA) Signature Date
Address Phone