



AT THE FOREFRONT OF **KIDS' MEDICINE**[®]

UChicago Medicine

Comer Children's

Pediatric Mobile Medical Unit

Dear Parent or Guardian:

It is our pleasure to partner with you in bringing the quality health care services to the children in our community schools. We stand ready to provide the highest quality of health care that your child deserves.

Attached is the official University of Chicago Medicine Comer Children's Hospital (UCMCCH) consent form that you will be required to fill out completely and return to your school/site or the staff on the Mobile Medical Unit.

Please be sure to complete and sign, when necessary, all sheets in this packet including:

1. Registration Form
2. Insurance Information and Disclaimer
3. Health History
4. Informed Consents

Adolescents who need sports physicals should have a **parent or legal guardian** fill out the history form and **sign**. Students or staff members should not be completing the IHSA form.

In order for your child to receive services at a scheduled site visit, please bring or send your child's shot record or other medical information from your child's past primary care provider, hospital, or clinic

We welcome you the parent/guardian to come with your child on their visit, but when this is inconvenient or not possible, know what we will make your child as comfortable as possible. You can expect us to deliver excellent care.

If at any time you have a question, concern, or comment about your child's medical visit, please be sure to contact us. You can reach our Program Coordinator at **(773)-834-8850**.

Sincerely,

The Pediatric Mobile Medical Unit Team



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REGISTRATION AND CONSENT FORM

All information must be completed in order for your child to be seen

Child's Name: _____

Date of Birth: ____/____/____

Sex Assigned at Birth: M F Intersex

Current Gender: Male Female Transgender-F (MTF) Transgender-M (FTM) Other: _____

Race: Black/African American Caucasian/White Asian American Indian Other: _____

Ethnicity: Hispanic/Latinx Non-Hispanic/Non-Latinx

Parent/Legal Guardian(s): _____

Relationship to Child: _____

Phone Number: _____ Home Cell

Email: _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip Code:** _____

Emergency Contact: Same as above

Emergency Contact Person: _____ Relationship to Child: _____

Emergency Contact Person Phone Number: _____

Insurance Type:

Medicaid (through the state)

Insurance #:

Private/PPO/HMO (through job)

Insurance #:

No Insurance

If you do not have insurance, please answer:

- If you do not have insurance, do you qualify for Federal or State assistance for school funds? (Such as free or reduced lunch program?) YES NO
- Are you interested in getting an All-Kids (State of Illinois insurance) application? YES NO

Does your child see a pediatrician, family practitioner, or nurse practitioner regularly?

No Yes

Provider's Name: _____

Clinic Name & Address:

Does your child currently see a specialist?

No Yes

List specialist(s) and reasons for seeing specialist:

CHILD'S PAST MEDICAL HISTORY

Pregnancy/Neonatal Period

Where was your child born?

Pregnancy Complications? NONE

Delivery by Vaginal C-section

Reason for C-section _____

Was your child premature? No Yes, born at _____ weeks

Birth Weight _____

Other Problems in the Newborn Period NONE

Infancy/Childhood/Adolescence

Has your **CHILD** ever been treated for/diagnosed with: (Explain)

- NONE
- Seasonal Allergies _____
- Food Allergies _____
- Anemia
- Asthma or Reactive Airway Disease or Wheezing
- ADD/ADHD
- Birth Defect or Genetic Syndrome
- Broken Bone
- Concussion/Head Injury
- Developmental Delay or Learning Disability
- Depression/Anxiety
- Diabetes
- Eczema
- Headaches
- Hearing Loss
- Heart Disease/Surgery
- Heart Murmur
- High Blood Pressure
- Recurrent Ear Infections
- Pneumonia
- Seizures
- Sickle Cell Trait/Disease or Bleeding Disorders
- Urinary Tract Infections
- Vision Problems
- Other Chronic Medical Condition/Explanation

Has your child ever been hospitalized? No

Yes [Explain + Date(s)]

Previous Surgeries and Dates NONE

Has your child visited the Emergency Department in the last 12 months? No

Yes [Explain + Date(s)]

Allergies to Medicine/Vaccines/Other NONE
(List and describe reaction)

Medications NONE

Current Prescribed Medications and Dose:

Vitamins/Herbal Supplements/Over-the-Counter Medications

Social History

Who lives in the child's household? Mom Dad
 Stepmom/dad Siblings (#_____) Grandparents
 Other _____

Do any household members smoke? Yes No

Any concerns about your child's performance in school? No

Yes _____

Family History

Do any family members have any of the following conditions:

NO FAMILY HISTORY OF DISEASE

Condition	Mother	Father	Sibling	Other (List)
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Blood Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sickle Cell Trait	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> _____

Human Papillomavirus (HPV) Vaccine

For children 9 years and older

I have read and understood the information given to me about the HPV vaccination, including the benefits, risks, and side-effects (Visit CDC's website at www.cdc.gov/hpv). I understand that multiple doses (2 or 3, depending on patient age) are needed to complete this vaccine series.

- Yes, please vaccinate my child with the HPV vaccine.
- No, please do not vaccinate my child with the HPV vaccine.
- No, my child already received the HPV vaccine.

Parent/Guardian Signature _____ Date _____



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INFORMED CONSENT

I, _____, Parent/Guardian of _____, _____
Parent/Guardian (print) Student Name (print)

understand that the physical examination, diagnosis, and treatment as described below, are being made available by the University of Chicago Medicine Comer Children's Hospital to currently enrolled children and adolescents in your institution. UCMCCH will provide these services to students in the Mobile Medical Unit that will be brought to the school or site premises. In cases of Chicago Public Schools (CPS), I understand that the CPS coordinator is not supervising the program, has no liability for this program, but will be working with the UCMCH's Program Coordinator in scheduling visits and follow-up care on the mobile unit.

- 1. Consent for Standard Care.** I hereby consent that the licensed physicians, nurse practitioners and nurses (staff) staffed on the UCMCCH Pediatric Mobile Medical Unit, may provide this child routine care as recommended by the American Academy of Pediatrics and by the UCMCCH protocols, policies, and procedures. This care may include medical care, screening for emotional well-being, vaccines, or blood tests. I understand that care does not include experimental medications or therapies and treatments outside of the services offered by the mobile unit. Staff will attempt to keep the regular physician, nurse practitioner or physician (primary care provider) indicated above, informed about any changes to this child's health.
- 2. Consent for Physical Exam, Diagnosis and Treatment, and Disclosure of Health Information.** I give the staff permission to perform a physical exam on my child for the purpose of school physical, sport physical or minor complain and to perform any diagnostic and therapeutic procedures deemed advisable by the health care provider and clinically indicated. Services provided may include, but not limited to, well child care, sick care and follow-up care. The patient/guardian signing this form hereby authorizes and requests the staff of the Comer Children's Hospital at the University of Chicago Medicine's Pediatric Mobile Medical Unit to disclosure and release information pertaining to the physical exam of the child's name on this consent form. The authorization is valid for the child's career at said school. The 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 University of Chicago Medicine's Privacy Practices, or otherwise allowable under Federal and State laws. By signing this consent form, you hereby acknowledge that you understand the information contained in the above Consent and Release of Health Information.
- 3. Consent to Provide Services Without a Parent/Guardian Being Present.** I hereby consent to have this child receive services from UCMCCH even if I am not present at the time these services are provided. I understand that if this child is seen and treated without me or another adult designated by me being present, the staff will attempt to contact me to discuss the child's condition and any treatment give. If medications are recommended during such an unaccompanied visit, I understand that it is my responsibility to pick these up from the Mobile unit and that this child will not leave the mobile unit with any medication if he/she is not accompanied by an authorized adult.
- 4. Consent to Share Information.** I further give my consent and authorization to UCMCCH to release and furnish my child's School Nurse, the completed school physical examination forms with sufficient medical details as is required by the school. I also give UCMCCH permission to release and furnish to this child's primary care provider, or to the specialty providers' written and verbal reports concerning any services provided to this child and any test results. I have read or have had explained to me all of the above information. I am giving this consent on my own free will. I have been told that I should feel free to discuss this child's disease(s), treatment proposal and prognosis with my primary care provider. I have been told that if I have any clinical questions, I may consent any of the PMMU clinical providers. I understand that if I have any questions about the program, I may contact the Program Coordinator of the Pediatric Mobile Medical Unit at (773)-834-8850. I understand that this consent and authorization are valid under the named child above leaves this school via graduation or transfer, or until I complete and sign a written Withdrawal of Consent form that I can obtain from my child's school principal, his/her designee or a member of the Pediatric Mobile Unit Staff. I further understand that this consent will remain in effect if the supervising providers change during the current school year. UCMCCH will notify me in writing of any such change and will send me new contact information.

5. **Consent for Study Participation.** I understand that I may be contacted to ask permission for my child to participate in a study and that my child cannot participate in a study without my written consent. Children who are 18 or older may provide their own consent for study participation.

Parent/Guardian's Signature	Relationship to Child	Date
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UCMCCH PMMU Staff or Collaborating Institution's Designee Only Below this Line:

The undersigned has read and explained the various sections 1 through 3 of this Consent to this Parent/Guardian, including the nature and purpose of the above described physical exam, immunizations, test and treatments and the risks that are applicable.

Staff Name Printed	Signature	Date
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Notice of Privacy Practices

I received a copy of the University of Chicago Medicine (UCMC) Notice of Privacy Practices.

Parent/Guardian's Signature	Relationship to Child	Date
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List of Institutions in UCMC's Organized Health Care Arrangement (UCMC OHCA)

The University of Chicago Medicine: 5841 S. Maryland Ave. Chicago, IL 60637
 Friend Family Health Center: 800 East 55th St. Chicago, IL 60615
 Child Life Center: 19550 Governors Highway, Flossmoor, IL 60422
 Regional Doctor's Offices



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FAMILY NEEDS ASSESSMENT

Please indicate if you would like to receive contact information for the following resources and the type of contact information you would prefer:

- Food Resource/Pantries
- Job Fairs & Job Training Resources
- Housing Resources
- Legal Advice
- Child Care
- Preventive Medical Care
 - Pediatric (Child)
 - Adult
- Subspecialty Medical Care
 - (Requires a referral from your Primary Care Physician)
- Grief Counseling
- Asthma Information
- Other: _____

Type of Contact Information:

Home/Cell Phone: _____

E-mail Address: _____

To best measure your family's food needs, please answer the following two questions. You may receive further telephone communication from our staff depending on your responses.

1. Within the past 12 months, we worried whether our food would run out before we got money to buy more.
 Yes No
2. Within the past 12 months, the food we bought just didn't last and we didn't have money to get more.
 Yes No



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CONSENT FOR TREATMENT

1. I have been informed and understand that this is a FREE MEDICAL CLINIC.
2. I have been informed and understand that all staff providing my care at this clinic are volunteers and receive no fees or compensation of any kind for providing my care.
3. I have been informed and understand that under the Illinois Good Samaritan law, the clinic and its staff are not liable for civil damages as a result of any negligent act or omission in providing my care.
4. I have read and understand this document and have been provided an opportunity to ask any questions I may have.

Printed Name of Patient

Signature

Date

(IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR, COMPLETE THE FOLLOWING):

Patient named is a minor, _____ years of age.

Signature of Person Authorized to Consent for Patient

Date

Relationship

Signature of Interpreter (if used)

Language

Date



Consent for Release/Exchange of Student Records and Information

Student's Name: _____

Date of Birth: ____ / ____ / ____

I hereby give permission to release/exchange/disclose the following:

All School Student Records, including, but not limited to: personally identifying information; cumulative-permanent record; special education records; academic transcript; discipline records; health records; attendance records; and test scores.

Only Specific School Records:

- Personally Identifying Information
- Cumulative/Permanent Record
- Progress Monitoring Data
- Other (Specify): _____
- Special Education Record (e.g. IEP, Evaluations, 504 Plans)
- Health Records
- Attendance Records
- Disciplinary Records
- Test Scores

Health/Medical Information:

- Any and all records in the possession of _____ including mental health, HIV and/or substance abuse records
- Records regarding treatment for the following condition or injury _____
- Records covering the period of time between _____ and _____
- Other: _____

This information is to be released/exchanged between:

Agency(ies)/School(s): University of Chicago Comer Children's Hospital Mobile Medical Unit
 Address: 5841 S. Maryland Ave, MC 6082 Chicago, IL 60637
 Attn: Pediatric Mobile Unit

AND

Chicago Public Schools, District #299
 School/Department: _____
 Attn: _____

Purpose: This information is to be disclosed upon request and will be used for the following purpose(s):

- Educational evaluation and program planning
- Health assessment and planning
- Independent Educational Evaluation
- Medical evaluation and treatment
- Referral to a separate day school/residential facility*
- Other: _____

These disclosures are authorized pursuant to the *Family Education Rights and Privacy Act* (20 U.S.C. Section 1232g), the *Illinois School Student Records Act* (105 ILCS 10/1 et seq.), and the *Illinois Mental Health and Developmental Disability Confidentiality Act* (740 ILCS 110/1 et seq.). I understand that I have the right to inspect and copy the information to be disclosed, challenge its contents, and limit my consent to designated records or portions of the information contained in those records. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the local school district representative. I understand that my revocation of this authorization will not be effective for actions taken by the school district or health care provider in reliance upon my authorization and prior to notice of my revocation. I understand that failing to authorize disclosure of records may adversely impact the educational programming and/or medical treatment for my child. I recognize that health records, once received by the school district may not be protected by HIPAA Privacy Rules, but will become educational records protected by the *Family Educational Rights and Privacy Act* (20 U.S.C. Section 1232g). I understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I understand that I have the right to inspect and copy educational records and to challenge their contents. *I acknowledge that limiting the release/exchange or disclosure of records to one separate day school/residential facility may impact the District's ability to timely place the Student in a non-public facility.

This authorization is valid for one (1) calendar year from the date of signed consent indicated below.

Parent Signature _____ Date _____

Student Signature* _____ Date _____

Witness Signature _____ Date _____

*Student signature required for mental health records if student is 12 years of age or older