AT THE FOREFRONT OF KIDS' MEDICINE
UChicago Medicine Comer Children's | Pediatric Mobile Medical Unit

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: _____ **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:

- Do you qualify for Federal or State assistance for school funds? (Such as free or reduced lunch program?)
  ☐ No ☐ Yes
- Are you interested in getting an All-Kids (State of Illinois insurance) application?
  ☐ No ☐ Yes

Patient Label

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

☐ Yes ☐ No

Provider's Name: _____

Clinic Name & Address:

_____

_____

Date of Last Visit: _____

Reason for Last Visit: _____

Does your child currently see a specialist?

☐ Yes ☐ No

List specialist(s) and reasons for seeing specialist:

_____

_____

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Patient Label

CHILD'S PAST MEDICAL HISTORY

Pregnancy/Neonatal Period

Where (hospital and/or city & state) was your child born?

_____

Pregnancy Complications or Problems in the Newborn Period?
☐ Yes [Explain] ☐ None

_____

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

Delivery ☐ Vaginal ☐ C-section Birth Weight _____

Infancy/Childhood/Adolescence

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

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

_____

_____

Past Hospital Stays and Dates ☐ None

_____

_____

Past Surgeries and Dates ☐ None

_____

_____

Emergency Room Visits in the Last 12 Months
☐ Yes [Explain + Date(s)] ☐ None

_____

_____

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

_____

_____

Medications ☐ None
Current Prescribed Medications and Dose(s):

_____

_____

Vitamins/ Herbal Supplements/ Over-the-Counter Medications

_____

Social History

Who lives with your child? ☐ Mom ☐ Dad ☐ Stepparent
☐ Sibling(s) (#____) ☐ 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:

Condition	Mom	Dad	Sibling	Other (List)
ADD or ADHD	☐	☐	☐	☐ _____
Anemia	☐	☐	☐	☐ _____
Asthma	☐	☐	☐	☐ _____
Cancer (Type: _____)	☐	☐	☐	☐ _____
Depression or Anxiety	☐	☐	☐	☐ _____
Diabetes	☐	☐	☐	☐ _____
Heart Disease	☐	☐	☐	☐ _____
High Blood Pressure	☐	☐	☐	☐ _____
High Cholesterol	☐	☐	☐	☐ _____
Kidney Disease	☐	☐	☐	☐ _____
Migraines	☐	☐	☐	☐ _____
Sickle Cell Trait or Disease	☐	☐	☐	☐ _____
Seizures	☐	☐	☐	☐ _____
Stroke	☐	☐	☐	☐ _____
Thyroid Disease	☐	☐	☐	☐ _____
Other _____	☐	☐	☐	☐ _____

☐ NO FAMILY HISTORY OF DISEASE

Human Papillomavirus (HPV) Vaccine

FOR CHILDREN 9 AND OLDER

For more information about the benefits, risks, and side-effects: go to the Centers for Disease Control and Prevention's (CDC's) website at www.cdc.gov/hpv.

- I read and understand all that was given to me about the HPV vaccination.
- I understand 2 or 3 vaccine doses may be needed based on the patient's age.

☐ Yes, give my child the HPV vaccine
☐ No, do not give my child the HPV vaccine.
☐ No, my child already received the HPV vaccine.

_____
Parent/Guardian Name (Print)

_____
Parent/Guardian Signature Date

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CONSENT FOR TREATMENT

I _____ am the parent or guardian of _____.
Parent/Guardian Name (Print) Child Name (Print)

The University of Chicago Comer Children's Hospital is called UCCCH or Comer. The doctors and nurse practitioners are called the healthcare team.

I understand:

- Comer runs a **Pediatric Mobile Medical Unit.** It is also called the **Pediatric Mobile Unit.**
- Children and teens in my child's school or education program may get health and medical care on the Pediatric Mobile Unit.
- Any exam, test, test results, or treatment is given by Comer medical staff.
- Care is given in the Pediatric Mobile Unit that comes to the school or other location.
- If I have any questions about the program, I may call the Pediatric Mobile Medical Unit program coordinator at (773)-834-8850.

Chicago Public Schools (CPS):

- I understand that CPS does not manage the Pediatric Mobile Unit program.
- CPS is not responsible in any way for this Pediatric Mobile Unit program.
- CPS works with the Pediatric Mobile Unit to plan visits and follow up care on the mobile unit.

Consent for Standard Care:

I agree that the healthcare team on the Pediatric Mobile Unit may give regular ongoing medical care to my child.

- Care given will follow what is recommended by the American Academy of Pediatrics.
- Care will follow UCCCH policies, procedures, and rules.
- Care may include medical care, testing for emotional well-being, vaccines, or blood tests.
- This permission for care **does not** include:
    - Medications or procedures still being tested.
    - Any treatments or therapy not given by the healthcare team on the Pediatric Mobile Unit.

Pediatric Mobile Unit staff will try to tell my child's primary care provider (listed on the registration) about any changes to my child's health.

I know I can ask questions and talk with:

- My child's primary care provider about my child's condition and any possible treatment.
- Anyone from the Pediatric Mobile Unit healthcare team about my child's condition, care, or treatment.

Consent for Exams, Diagnosis and Treatment, and Disclosure of Health Information:

As the parent or guardian, I give permission for the healthcare team on the mobile unit to:

- Give my child an exam for school, sports, or for any minor problem.
- Give tests, procedures, and care that is needed to know and treat my child's condition. This may include, but is not limited to, well-child care, sick care, and follow-up care.
- Share information about my child's exam with my child's school, following all laws that apply.

Consent to Provide Services Without a Parent or Guardian Being Present:

I give my permission for this child to get services from UCCCH even if I am not with my child when these services are given.

I understand:

- This child may be seen and treated without me, or another adult allowed by me.
- The Pediatric Mobile Unit team will try to contact me to talk about the child's condition and any treatment given.
- Any medications recommended during this visit must be picked up by me or an adult allowed by me. Staff will not send medications home with the child unless one of us is also home.

Consent to Share Information:

I give my permission for UCCCH to give and share:

- All school health and medical forms with my child's school nurse.
- Written and verbal reports about my child's test results and care with this child's primary care provider or specialty providers.
- Permission to share information will stay in effect for the time the child is a student at CPS.
    - Consent to share information may be removed at any time.
    - If I remove my permission, I know my child's information may still be shared as described in the UChicago Medicine Privacy Practices, or otherwise allowed under Federal and State laws.

CONSENT FOR TREATMENT (Continued)

Consent for Taking Part in Research:

I understand:

- I may be contacted to ask permission for my child to take part in a research study.
- My child cannot take part in a study without my written consent.
- Children who are 18 or older may give their own consent for taking part in a research study.

This consent (permission) will stay in effect until the child graduates, transfers or leaves Chicago Public Schools.

- I can remove my permission by filling out and signing a written Withdrawal of Consent.
- I can get this form from my child's school principal or representative, or a member of the Pediatric Mobile Unit staff.

This consent will stay in effect during any change of the supervising provider on the Pediatric Mobile Unit in the current school year, UCMCCH will tell me in writing of any changes and send me new contact information.

I have read all the information above, or it was explained to me. I am giving this consent of my own free will. By signing below, I am saying I understand the information in this form.

Parent/Guardian Name (Print): _____ Relationship to Child: _____

Signature: _____ Date: _____

This section is for staff only:
Comer Pediatric Mobile Unit Staff or Person designated from school or organization working with the Pediatric Mobile Unit.

The person signing here has read and explained all parts of this Consent to this parent or guardian. This includes the reason and purpose of any physical exams, vaccines, tests, and treatments, and any possible risks.

Staff Name (Print) Signature Date

NOTICE OF PRIVACY PRACTICES

Sign below if you were given the Notice of Privacy Practices for UChicago Medicine.

Parent/Guardian's Signature Relationship to Child Date

Institutions in UCMC Organized Health Care Arrangement (UCMC OHCA)

- The University of Chicago Medical Center (UCMC) including its nurses, residents, other staff, and volunteers
- Parts of the University of Chicago that take part in or support the activities of health care, including its doctors, nurses, students, volunteers, and other staff
- UCM Community Physicians, LLC
- UCM Care Network Medical Group, Inc.
- Primary Healthcare Associates, SC
- Any affiliated entity that that may be added

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Pediatric Mobile Medical Unit

GOOD SAMARITAN CONSENT FOR TREATMENT

I was told and understand:

- This is a **Free Medical Clinic.**
- All staff providing my care at this clinic are volunteers.
  They are not paid in any way for providing care to me.
- 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 any care.
  This means in most cases, they cannot be sued for giving or leaving out care.

I have read and understand this form and have been able to ask any questions.

Patient Name (Print): _____ Patient Date of Birth: _____

If patient over age 18:

Signature: _____ Date: _____

If patient is a minor (under the age 18) or is not able to give consent, fill out the following information:

The patient named here is a minor, _____ years of age.

Person who can give consent for patient:

Parent/Guardian Name (Print): _____ Relationship to Child: _____

Signature: _____ Date: _____

This section is for staff only:

Language of Interpreter (If used): _____

_____

Interpreter Name (Print) Signature Date

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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

___ Grief Counseling

___ Asthma Information

___ Other: _____

Preferred Method of Contact

☐ **Mail**

Parent's Name: _____

Address: _____

_____

☐ 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

PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____