Loyola University Medical Center

Mobile Medical Unit — Health Care/Immunization Consent Form

Child's Name (Please Print)	Date of Birth	Sex M F	
Address	City	State	ZIP
Phone	Mother's Name		Phone if Different Than Child's
Family Doctor? Yes No	Father's Name		Phone if Different Than Child's
Doctor's Name	Guardian's Name (If Applicable*)		Phone if Different Than Child's
Doctor's Phone	Doctor's Clinic/Office Site Where Care Rendered		

Date of Last Doctor's Visit: _____ Reason: _____

□ Yes □ No Has the child missed any school because the physical/immunizations have not been done?

If yes, how many school days have been missed? _____

□ Yes □ No Does the child have known health problems and/or illnesses being treated? (List): _____

□ Yes □ No Any history of cancer, leukemia, HIV or immunodeficiency? If yes, please list: _____

□ Yes □ No Taking any medication? (List): _____

□ Yes □ No Any allergies (List): _____

□ Yes □ No Any specific allergy to neomycin, streptomycin, gelatin, baker's yeast or eggs?

□ Yes □ No Any reaction to previous vaccinations especially seizure, fever (105 or above), anaphylaxis, rash or change in mental state?

If yes, please explain: _____

□ Yes □ No For teenage girls being seen, could you be pregnant?

□ Yes □ No Has your child been to the Emergency Room this last year?

If yes, list reasons: _____

Child's Family History - Place the initial M, F, S, B, G, A, U for each family member affected with each condition listed below:

(M=Mother, F=Father, S= Sister, B=Brother, G=Grandparent, A=Aunt, U=Uncle)

Heart Disease	Cancer	High Cholesterol	Asthma	Diabetes
High Blood Pressure	Growth Problem	Seizures	Other	

Vaccine Consent

I have read, or had explained to me, the Vaccine Information Statement about the vaccination(s) that I will receive today. I have had a chance to ask questions which were answered to my satisfaction, and I understand the benefits and risks of the vaccination(s) as described. I request that the vaccination(s) checked below to be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary for treatment, payment, health care operations, and any public health purpose.

_____

Signature of Recipient (Parent or Guardian) Date

Check All Vaccinations for which this Consent is Granted:

Polio (IPV)		Menactra (MCV4)	
Mumps, Measles, Rubella (MMR)		Haemophilus Influenza (Hib)	
Diptheria, Tetanus, Pertussis (DTP)		Tetanus, Diptheria, Pertussis (Tdap)	
Tetanus, Diptheria (TD)		Human Papillomavirus (HPV)	
Hepatitis A (HepA)		Hepatitis B (HepB)	
Influenza (FLU)		Other _____	

If applicable, I acknowledge the receipt of a copy of the **LUHS Notice of Privacy Practices.**

_____

Signature of Recipient (Parent or Guardian) Date

Health Care Consent

I understand that Loyola University Medical Center ("LUMC") offers health care services ("Services") and I consent to such services. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my treatment and I consent to their involvement in my care.

Patient Information: I acknowledge and agree that LUMC may receive, use and disclose information concerning my care, my prescription medications and my health care coverage for treatment, payment and health care operations including but not limited to the disclosures described in its Notice of Privacy Practices. I agree that LUMC, including its business associates, may contact me by telephone at any telephone number provided by me or associated with my record, including cell phone numbers, which could result in charges to me. LUMC may also contact me by sending text messages or e-mails, using the contact information I provide. Methods of contact may include, but are not limited to, using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Because different types of Services are offered by LUMC, I hereby consent to having my child receive all the Health Care Services checked below.

Check All Health Care Services for which this Consent is Granted:

Physical Examination		Health Screening	
Educational Session(s)		Lab Tests	
Nutrition Education		Asthma Care	

I have had the opportunity to read and fully understand this consent for its content and significance. I agree with the information contained in this consent and confirm that I am the patient or am authorized to sign on the patient's behalf.

_____

Signature of Recipient (Parent or Guardian) Date

***** I understand that as a substitute caregiver to a Chicago Public School student under the legal guardianship of the Illinois Department of Children and Family Services (DCFS) I am not authorized to provide written Consent for Ordinary and Routine Medical and Dental Care. I further understand that I must request consent from the DCFS Guardianship Administrator, or Authorized Agent, and provide a copy of the DCFS Consent for Ordinary and Routine Medical and Dental Care if consent is granted before any of the above services may be provided.

Form Revised 7-30-12