Loyola University Medical Center

Mobile Medical Unit Care/Immunization Consent Form

Health

Child's Name (Ple	ease Print)		Date of	Birth	Sex M	F		
Address			City		State	ZIP		
Phone			Mother's	s Name	<u> </u>	Phone if Different Th	an Child's	
Family Doctor?	Yes	No	Father's	s Name		Phone if Different Th	an Child's	
Doctor's Name			Guardia	n's Name (If Applicable*)		Phone if Different Th	an Child's	
Doctor's Phone			Doctor's	s Clinic/Office Site Where Ca	re Rendered			
Date of Last Doc	tor's Visit:	Reas	on:					
□ Yes □ No	Has the c		ecause the physical/immuniza		e?			
			If yes, how many schoo	l days have been missed	?	_		
□ Yes □ No	Does the	child have known health	problems and/or illnesses beir	ng treated? (List):				
□ Yes □ No	Any history of cancer, leukemia, HIV or immunodeficiency? If yes, please list:							
□ Yes □ No	Taking any medication? (List):							
□ Yes □ No								
□ Yes □ No	Any specific allergy to neomycin, streptomycin, gelatin, baker's yeast or eggs?							
□ Yes □ No	Any react	tion to previous vaccination	ns especially seizure, fever (1	I05 or above), anaphylax	is, rash or change	in mental state?		
If y	es, please e	xplain:					-	
□ Yes □ No	For teena	age girls being seen, coul	d you be pregnant?					
□ Yes □ No	Has your	child been to the Emerge	ncy Room this last year?					
			If	yes,	list		reasons	
Child's Family Hi	story - Place	the initial M, F, S, B, G, A	, U for each family member af	fected with each conditio	n listed below:			
		(M=Mother, F=	Father, S= Sister, B=Brother,	G=Grandparent, A=Aun	t, U=Uncle)			
Heart Disease		Cancer	High Cholesterol	Asthma		Diabetes		
	ssure	Growth Problem	Seizures	Other				

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

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	

Check All Vaccinations for which this Consent is Granted:

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.

^{*} 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.

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

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