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CONSNT

CoxHealth
Regional Services
C.A.R.E. MOBILE REGISTRATION

Name:
Age: DOB: ___/___/_____
MRN:
(For Internal Use or Patient Sticker Here)

Child's Legal Name: _____ Birth Date: _____/_____/_____ Sex: Male Female
Address: _____ City: State: _____ Zip:
School: Primary Language: English Spanish Other:

FINANCIAL OBLIGATION*

** The mission of the C.A.R.E. Mobile program is to provide access to health care for children in the Ozarks who have no insurance, do not have a primary care physician or whose parents cannot afford to pay for necessary services. However, no child will be turned away.*

NO INSURANCE (SELF PAY): _____

PRIMARY INS: _____ **POLICY HOLDER NAME:**

Policy Holder's Employer:
Group #: Policy/ID #: Policy Holder DOB: ___/___/_____
Patient's Relationship to Policy Holder: Child Other (explain)

PARENT OR GUARDIAN and EMERGENCY CONTACT INFORMATION

Emergency Contact: Phone: Relationship:
RELATIONSHIP: Father Mother Guardian
Name: (First, MI, Last) Date of Birth: ___/___/_____
Address: City/State/Zip: Home Phone:
Employer: Work Phone: Mobile Phone:
Preferred method of contact? Email Home Phone Letter Mobile Phone Work Phone

SCREENING CHECKLIST FOR CONTRAINDICATIONS TO VACCINES

For parents/guardians - (***Only complete this section if your child is being vaccinated by the C.A.R.E. Mobile***):
The following questions will help us determine which vaccines your child may be given. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

1. Is the child sick today? YES NO UNKNOWN
2. Does the child have allergies to medications, food, a vaccine component, or latex? YES NO UNKNOWN
3. Has the child had a serious reaction to a vaccine in the past? YES NO UNKNOWN
4. Has the child had a health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, or a blood disorder? YES NO UNKNOWN
5. Is he/she on long-term aspirin therapy? YES NO UNKNOWN
6. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? YES NO UNKNOWN
7. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems? YES NO UNKNOWN
8. In the past 3 months, has the child taken medications that affect the immune system? such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments? YES NO UNKNOWN
9. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug? YES NO UNKNOWN
10. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? YES NO UNKNOWN
11. Has the child received vaccinations in the past 4 weeks? YES NO UNKNOWN

Please send your child's immunization record card with them on the day of their visit to the C.A.R.E Mobile.
If you would like your child to receive immunizations on the Medical Mobile Unit, please complete this form. All vaccines are provided with no out-of-pocket expense for your child/family. If you do have insurance, CoxHealth will send a bill to your insurance company. You are not responsible for any charges not covered by your insurance company.

Parent Signature: _____ Date: _____

_____

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VACCINE RECORD (FOR C.A.R.E. MOBILE USE ONLY)

Vaccine for Children's Program: _____ Insurance: _____

Vaccine	Brand Name/MFGS	Lot #	EXP	Site	Route	Nurse Administering Vaccine Signature & Credentials	Dose #	Next Dose Due
Flu	Flulavel/ID Biomedical				IM			
Nurse Administering Vaccine (Please Print Name):								
School Site:						**Date Given:**		