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CONSENT

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: _____

Children's Miracle Network Hospitals
Helping Local Kids

CoxHealth

Dear Parents/Guardians:

The CoxHealth CARE Mobile is working with the Springfield School District during April and May to provide middle and high school students with Missouri required and CDC recommended vaccinations. Our CARE Mobile will provide this service on-site during the school day and parents are not required to be present. You will need to complete both sides of this form and return it to the school nurse at your child's school.

Please review and initial the vaccines that you want administered to your child:

REQUIRED FOR ENTRY INTO 8th Grade:	**REQUIRED FOR ENTRY INTO 12th Grade:**	**Other required vaccines needed for school attendance:**
TDAP: _____ Meningococcal Conjugate (MCV4)-DOSE ONE: _____	Meningococcal Conjugate (MCV4) DOSE TWO (*unless first dose administered after age 16*): _____	_____ Hepatitis B _____ Polio _____ Varicella _____ MMR

Recommended by the CDC, if student has not already completed these vaccine series:

Hepatitis A (2 shot series): _____ Human Papillomavirus (Age 11 or order): _____

_____ I authorize CoxHealth to administer the checked vaccinations to my child.
_____ I would like vaccine information sheets regarding the vaccines given sent home with my child.
_____ I have had the opportunity to ask questions concerning the above selected vaccine(s), the administration of the vaccine(s) and potential adverse health consequences of receiving the vaccine(s), and all of my questions have been answered to my satisfaction.
_____ I understand my child is not required to receive the selected vaccine(s) at the CARE Mobile; however, I have voluntarily chosen to have them administered and accept all known and potential risks related to receiving the selected vaccine(s).

By signing below, I consent to the administration of the selected vaccine(s) by representatives of CoxHealth. I fully release and discharge CoxHealth, its affiliates and officers, directors, employees and persons acting on its behalf or at its direction from any liability or claim related to the administration of, or my receipt of, the selected vaccine(s).

Parent/Guardian Signature: _____ Date: _____

Student Name: _____ DOB: _____

To find the CDC vaccine information sheets regarding all the above vaccines, please visit https://www.cdc.gov/vaccines/hcp/vis/current-vis.html

Please complete both sides of the form.