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| **llll Ill hl lll hl lull l**  \*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

1. Is he/she on long-term aspirin therapy? YES NO UNKNOWN
2. Has the child, a sibling, or a parent had a seizure; has the child had brain or other

nervous system problems? YES NO UNKNOWN

1. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other

immune system problems? YES NO UNKNOWN

1. 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

1. 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

1. Is the child/teen pregnant or is there a chance she could become

pregnant during the next month? YES NO UNKNOWN

1. 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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| \*CONSNT\* | **CoxHealth**  Regional Services  **C.A.R.E. MOBILE REGISTRATION** | Name:  Age: DOB: \_\_\_/\_\_\_/\_\_\_\_\_\_  MRN:  (For Internal Use or Patient Sticker Here) |

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

Vaccine for Children’s Program: \_\_\_\_\_\_\_\_\_\_\_ Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Vaccine** | **Brand**  **Name/MFGS** | **Lot #** | **EXP** | **Site** | **Route** | **Nurse Administering Vaccine**  **Signature**  **& Credentials** | **Dose #** | **Next Dose Due** |
| Tdap  (11-18yo) | Adacel/SP  Boostrix/GSK |  |  |  | IM |  |  |  |
| Dtap/IPV  (4-6 yo) | Kinrix/GSK |  |  |  | IM |  |  |  |
| Dtap | Infanrix/ GSK |  |  |  | IM |  |  |  |
| MCV4 | Menactra/SP  Menveo/GSK |  |  |  | IM |  |  |  |
| HPV | Gardasil/Merck |  |  |  | IM |  |  |  |
| MMR | MMR/Merck |  |  |  | SQ |  |  |  |
| Varicella | Varivax/Merck |  |  |  | SQ |  |  |  |
| MMRV | ProQuad/Merck |  |  |  | SQ |  |  |  |
| IPV | Polio/SP |  |  |  | IM |  |  |  |
| Hep A | Havrix/GSK Vaqta/Merck |  |  |  | IM |  |  |  |
| PCV 13 | Prevnar/Pfizer |  |  |  | IM |  |  |  |
| Hep B | Engerix/GSK |  |  |  | IM |  |  |  |
| HIB | Pedvax/Merck ActHIB/SP |  |  |  | IM |  |  |  |
| **Nurse Administering Vaccine (Please Print Name):** | | | | | | |  |  |
| **School Site: Date Given:** | | | | | | |  |  |