CONSNT

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

Name: ______________________
Age: ______ DOB: ___/___/______
SSN or ID: ____________________
(or Patient Sticker Here)

Child's Legal Name:________________________________ SSN#: ____________________ 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.*

STUDENT QUALIFIES FOR FREE OR REDUCED LUNCH? ☐ Yes ☐ No ☐ **NO INSURANCE** (SELF PAY)

PRIMARY INS:__________________________ **POLICY HOLDER NAME:** ______________________________
Policy Holder's Employer: ______________________ Policy Holder SSN#: ______________________________
Group #: ________________________ Policy/ID #: __________________________ Policy Holder DOB: ___/___/______
Patient's Relationship to Policy Holder: ☐ Child ☐ Other (explain) ____

SECONDARY INS:__________________________ **POLICY HOLDER NAME:** ______________________________
Policy Holder's Employer: ______________________ Policy Holder SSN#: ______________________________
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) ________________________________ SSN#: ________________ 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
RELATIONSHIP: ☐ Father ☐ Mother ☐ Guardian
Name: (First, MI, Last) ________________________________ SSN#: ________________ 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

FAMILY HISTORY

Ethnicity: ☐ Hispanic or Latino ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander

Patient's biological family has a history of:

☐ Stroke ☐ Heart disease or heart attack ☐ Diabetes/sugar disease ☐ High blood pressure
☐ High cholesterol ☐ Diabetes/sugar disease ☐ Asthma ☐ Hearing loss at young age
☐ Vision loss at young age ☐ Alzheimer's disease/dementia ☐ Developmental delay/retardation ☐ Miscarriage/stillbirth
☐ Breast cancer ☐ Ovarian cancer ☐ Endometrial (uterine) cancer ☐ Colon cancer
☐ Birth Defects ☐ Genetic conditions: ____

☐ Other Cancer(s): ____
☐ Genetic Conditions: ____
☐ Mental Health: ____
☐ Other Health Concerns: ____

Identify family members with each condition checked:

Relationship	Condition	Age of Onset	Current Age	Age and Cause of Death
Example: Grandmother on Father's Side	*High Blood Pressure*	*61*		*87, Stroke*

CONTINUED ON BACK

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CONTINUED FROM FRONT

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 ☐ Don't Know
2. Does the child have allergies to medications, food, a vaccine component, or latex? ☐ Yes ☐ No ☐ Don't Know
3. Has the child had a serious reaction to a vaccine in the past? ☐ Yes ☐ No ☐ Don't Know
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 ☐ Don't Know
   Is he/she on long-term aspirin therapy? ☐ Yes ☐ No ☐ Don't Know
5. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems? ☐ Yes ☐ No ☐ Don't Know
6. Does the child or a family member have cancer, leukemia, HIV/AIDS, or any other immune system problems? ☐ Yes ☐ No ☐ Don't Know
7. 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 ☐ Don't Know
8. 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 ☐ Don't Know
9. Is the child/teen pregnant or is there a chance she could become pregnant during the next month? ☐ Yes ☐ No ☐ Don't Know
10. Has the child received vaccinations in the past 4 weeks? ☐ Yes ☐ No ☐ Don't Know

Please send your child's immunization record card with them on the day of their visit to the C.A.R.E Mobile.

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter daycare or school, for employment, or for international travel.

______________________________ ____________
Parent Signature Date

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

Vaccines for Children (VFC) Program Eligibility Status: ☐ Medicaid ☐ No health insurance ☐ American Indian/Alaska Native ☐ Underinsured (FQHC/RHC) Diphtheria, Tetanus ☐ NOT VFC Eligible

Vaccine	Route	M/D/Y Given	Injection Site	Manufacturer	Lot Number	Exp. Date	NDC Number	VIS Rev. Date	Date VIS Given
Ex.: Hib	*IM*	*01/01/18*	*Left Arm*	*Sanofi Pasteur*	*AA123AA*	*01/01/18*	*49281-547-58*	*01/01/18*	*01/01/18*

Comments: ____

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______________________ ______________________ ____________
Vaccinator Signature Vaccinator Title Date