Ronald McDonald Care Mobile®

Patient Registration – August 2013.May 2014

For an appointment call (423) 298-4469

Patient Information:

_____ _____

Student's Last Name First Middle

_____ _____

Student's Address City State Zip

_____ _____ _____ _____

Student's Social Security Number Date of Birth School Grade

Sex: M F Race: (Please Circle One) White Black Hispanic Asian Bi-Racial Other

Primary Care Physician: _____

Parent/Guardian Information:

Parent/Guardian's Name: _____ Date of Birth: _____

Parent Employer: _____

Home Phone #: _____ Mobile Phone #: _____

Insurance Information: Please fill in all the information so that we do not have to copy your card.

My child has: ___ No Insurance

___ TennCare -ID# _____

___ Cover Kids – ID # _____

___Private/Commercial Insurance Provider **(please provide details below)**

Primary Insurance Company: _____

Name of Policy Holder: _____ Relationship to Student: _____

Member ID or Policy# _____ Group # _____ Co-Pay: $_____

Social Security # of Policy Holder: _____ Policy Holder Date of Birth: _____

Emergency Contact Information: Alternate contact if parent/guardian is unable to reach.

Name: _____ Relationship: _____ Phone #: _____

(May We Leave A Message?) Yes No

As a Parent/Guardian of the above student:

I authorize the release of any medical information necessary to process an insurance claim for payment of medical benefits to the Ronald McDonald Care Mobile® School Based Medical Clinic.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian PRINTED Name** **Date**

Registration Continued on Next Page ►

Student Health History

Student's Name: _____ **Date of Birth:** _____

School Attending: _____

Patient's Medical History

ADD/ADHD	Yes	No	Heart Disease	Yes	No
Asthma	Yes	No	Kidney/Renal Disease	Yes	No
Bladder/Urinary Problems	Yes	No	Nosebleeds	Yes	No
Blood Disorder	Yes	No	Pneumonia	Yes	No
Bowel Problems/Constipation	Yes	No	Premature Birth	Yes	No
Cancer/Leukemia	Yes	No	Spine Disorders	Yes	No
Depression/Anxiety	Yes	No	Seizures	Yes	No
Diabetes Mellitus	Yes	No	Sickle Cell	Yes	No
Earaches/Ear Infections	Yes	No	Stomach Aches	Yes	No
Eczema	Yes	No	Wears Glasses or Contacts	Yes	No
Frequent Infections	Yes	No	Wears Hearing Aid	Yes	No
Headaches	Yes	No	Weight Issues	Yes	No

Other (please list): _____

Current Medications:

Does your child take any medications? Yes No

If yes, please list medications: _____

_____

Allergies:

Does your child have allergies? Yes (if yes, please list allergies below) No

Food Allergies: _____

Medication Allergies: _____

Animals or insects: _____

Allergies Require Epi Pen? Yes No

Asthma Information:

Does your child have an inhaler? Yes No Type of inhaler: _____

Will your child bring inhaler to school? Yes No

Does child use a nebulizer at home? Yes No

Surgeries/Hospitalizations:

Has your child stayed overnight in the hospital? Yes No

Has your child had a serious injury? Yes No

Has your child had surgery? Yes No

Number of visits to the Emergency Room last year? _____

If yes, please list: _____

Family History

Have any Blood Relatives of your child had the following problems? (Please check all that apply.)

☐ Anemia	☐ AIDS	☐ High Blood Pressure	☐ Sickle Cell
☐ Diabetes	☐ High Cholesterol	☐ Asthma	☐ Drugs
☐ Headaches/Migraine	☐ Muscle or Joint Problems	☐ Stroke	☐ Tuberculosis
☐ Sudden Infant Death	☐ Arthritis/Birth Defect	☐ Alcoholism	☐ Seizures
☐ Early Deafness	☐ Cancer	☐ Heart Disease	☐ Cystic Fibrosis

Social History

Exposed to cigarette smoke at home? Yes No Living with parents? Yes No

Signature

_____ _____ _____

Guardian's Signature | Guardian's Printed Name | Date

Ronald McDonald Care Mobile®
School Based Medical Clinic
Consent to Treat

Name of Child: _____ Date: _____
(Please Print Full Name)

School Attending: _____

I, the undersigned, hereby, consent for my above-named child to receive health care services at the Ronald McDonald Care Mobile® School Based Medical Clinic, which is staffed by State-licensed professionals of Children's Hospital at Erlanger. School based medical clinic services include, but are not limited to medical care and treatment, including diagnosis of acute and chronic illness and disease and prescribing medications.

I understand that the school health staff or the Ronald McDonald Care Mobile® Staff will notify me prior to my child's encounter with the medical provider. I hereby give my permission for my child to receive care at the Ronald McDonald Care Mobile® School Based Medical Clinic whether or not I can accompany my child to the medical clinic each time.

I authorize the Ronald McDonald Care Mobile® School Based Medical Clinic staff to disclose all or any portion of my child's medical record to persons or entities pertinent to his/her health care, including but not limited to his/her primary care physician, the school nurse and the Ronald McDonald Care Mobile® staff.

I further understand that all information in my child's medical record is confidential and will not be released to any unauthorized person or agency without written consent. I acknowledge that I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices of the Ronald McDonald Care Mobile® School Based Medical Clinic.

I authorize staff to summon emergency services (9-1-1) for my child if necessary. Expenses related to ambulance or other emergency referral will be my responsibility.

I give consent to release any information regarding treatment to third party payers (insurance) for the purpose of billing.

I will attempt to make myself available for communication regarding my child's health needs. I understand that there are certain hazards and risks connected with all forms of treatment and consent is given in light of this knowledge. I understand it is my duty to inform the Ronald McDonald Care Mobile® staff of any change in the child's guardianship.

I also certify, by signing this form, that I am legally authorized to provide this consent. This consent will remain in force for a period of one year, or until I revoke said consent in writing.

_____	_____	_____
Parent/Guardian Signature	**Parent/Guardian PRINTED Name**	**Date**

Over ►

Name of Child: _____ Date: _____

School Attending: _____

HIPAA Notice of Privacy Practices

I understand, that as, part of my health care, Erlanger Health System, receives, originates, maintains, discloses, and uses my protected health information, including, but not limited to, health records and other health information describing my health history, symptoms, examinations and test results, diagnoses, treatment, treatment plans, and billing and health insurance information. Health information is maintained both in paper format and electronic media. I authorize Erlanger Health System to use this information for the purpose of treatment, payment, or healthcare operations. This authorization specifically includes the release of medical information concerning drug-related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or infectious diseases included but not limited to blood-borne diseases. I understand that I may revoke this consent in writing and Erlanger Health System will comply if possible. However, Erlanger Health System will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

I have been provided a ***Notice of Privacy Practices*** that fully explains the uses and disclosures that Erlanger Health System may make with respect to my protect health information. I understand that I have the right to review the **Notice** before signing this consent. I also understand that Erlanger Health System reserves the right to change the ***Notice of Privacy Practices*** and should the privacy practices change, I will be notified of any changes upon my next visit to Erlanger Health System. Also, I may obtain a current copy of this notice at **www.erlanger.org**.

I understand that I do not have to consent to use or disclosure of my protected health information for treatment, payment, and health care operations. If I do not consent, Erlanger Health System may refuse to provide me health care services unless applicable state or federal laws require Erlanger Health System to provide such services.

I understand that I have the right to request restriction on the use or disclosure of my protect health information to carry out treatment, payment, or health care operations. I further understand Erlanger Health System is not required to agree to the requested restriction but that, if it does agree, it is bound by such agreement. If a request for restriction on the use or disclosure of individually identifiable health information is made the Corporate Privacy and Security Officer (CPSO) is to be notified immediately. No one is authorized to accept a request for restriction other than the CPSO.

I understand that I may revoke this authorization in writing and Erlanger Health System will comply if possible. However, Erlanger Health System will not be held responsible for any actions or disclosures already taken prior to revocation of this authorization.

Signature of Parent or Legal Representative

_____

Relationship to Patient

_____

Date: _____