St. Bernard Hospital Mobile Pediatric Health Unit

will be at T.F. South High School

18500 Burnham Avenue
Lansing, IL

9th Grade physicals and Immunizations

Thursday, July 25, 2013
Monday, July 29, 2013
Wednesday, July 31, 2013

9:00 a.m. – 1:30 p.m.

By Appointment ONLY

1. Make an appointment
2. Parent must complete consent/registration form
3. Parent must complete, sign and date Health History on physical form
4. Parent must provide COMPLETE immunization record
5. Bring all completed forms to your appointment

To schedule an appointment or for additional information contact
Mrs. Patricia Oostman, TF South School Nurse
708-585-2050

OR (*after* May 31st)

Mrs. Kim Taylor, Guidance Office Administrative Assistant
708-585-2024 or 708-585-2000

ST. BERNARD HOSPITAL

326 West 64th Street, Chicago, Illinois 60621

PEDIATRIC MOBILE HEALTH UNIT CONSENT/REGISTRATON FORM

<u>All information must be completed in order for your child to be seen</u>

Child's Name:_____ Date of Birth:_____

Phone Number:_____ Sex: ☐Male ☐Female

Street Address: _____ Apt. #_____

City:_____ State:_____ Zip Code:_____

Mother's Name:_____ Father's Name:_____

<u>INSURANCE INFORMATION</u>: Check only one

☐ Medicaid ☐ Native American or Alaskan Native ☐ Health insurance does not pay for vaccines ☐ Does not have health insurance

Medicaid or All Kids Insurance I.D. Number _____

1. Has this child missed any school because a physical exam or immunizations have not been done? ☐Yes ☐No If yes, how many school days have been missed? _____
2. Name of Family Doctor:_____
   Location: _____
3. Date of last visit: _____ Reason:_____
4. List all known health problems and/or illnesses being treated: _____
5. Does your child have any history of cancer, leukemia, HIV/AIDS? ☐Yes ☐No If yes, please list:_____
6. List any allergies: _____
7. Any specific allergy to neomycin, streptomycin, gelatin, baker's yeast or eggs? ☐Yes ☐No
8. Any reaction to previous vaccinations (seizures, fever 105 or above, anaphylaxis, rash, or change in mental state?
   ☐Yes ☐No If yes please explain: _____
9. How many times has your child been to the Emergency Room this year? _____ List reasons: _____
   _____
10. For teenage girls being seen, could she be pregnant? ☐Yes ☐No
11. Is there a family history of any conditions listed below? If so, place the initial for each family member affected with each condition (M=mom, F=dad, S=sister, B=brother, G=grandparent, A=aunt, U=uncle).
    Heart Disease _____Cancer_____High Cholesterol_____Asthma_____Diabetes _____
    Hypertension_____ Seizure_____ Sickle Cell_____ Other_____
12. Has your Daughter started the Gardasil vaccine series?___ Yes,___No (Gardasil info available on Pediatric Mobile Unit)
13. If no, would you like her to start the series? ____Yes, ____No
14. Can we give your child the seasonal flu shot. ____Yes, ____No

<u>IMMUNIZATION AND PHYSICAL EXAM CONSENT</u>

I give the staff of St. Bernard Hospital Pediatric Mobile Health Unit permission to give all recommended and required immunizations and perform a physical exam of my child identified above. I also give permission for information regarding this immunization/physical exam or associated follow-up to be shared with my child's school and for the immunization information to be registered with the I-CARES program.

Signature: _____ **Date:** _____

Print Name: _____ **Relationship: PLEASE CHECK ONE Parent____Guardian_____**

Occasionally St. Bernard Hospital takes children's pictures for promotional material. Check here__if you **do not** want us to take your child's picture.

<u>Does your child have a Doctor?</u> Yes_____ No ____

If **No**, can someone from Partners in Health contact you about a Doctor for your child? **Yes___ No___**

<u>Does your family have a Dentist?</u> Yes___ No___

If **No**, can someone from the St. Bernard Hospital Dental Center contact you about their services? **Yes____ No___**

<u>FOR ENGLEWOOD RESIDENTS:</u>

<u>Does your child have Asthma?</u> Yes____ No_____

If **Yes**, can someone from the Addressing Asthma in Englewood program contact you to explain their free program? **Yes___ No___**

ST. BERNARD HOSPITAL

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PEDIATRIC MOBILE HEALTH UNIT CONSENT/REGISTRATION FORM

Toda la información debe estar completa para que su niño(a) pueda ser examinado(a)

Nombre de niño(a): _____ Fecha de nacimiento: _____

Numero de teléfono: _____ Sexo _____

Domicilio: _____ Apt.# _____

Ciudad: _____ Estado: _____ Código postal: _____

Nombre de madre: _____ Nombre de padre: _____

Tiene El Nino Seguro: (Circule uno)

□ Tarjeta Medica □ Indio Nativo Americano o de Alaska □ Otra aseguranza que no paga por vacunas □ No tengo aseguranza

El numero de Medicaid or de All Kids I. D. Numero _____

1. Su niño(a) ha perdido clases por la razón de no tener el fisico/vacunaciones? □SI □No
   Si ha perdido clases, cuantos días ha perdido? _____
2. Nombre de el doctor familiar: _____
   Dirección: _____
3. Última visita: _____ Razón: _____
4. Tienes algún problema(s) medico y/o enfermeda(s) en tratamiento? (lista): _____
5. História de cancer, lucemia, VIH, SIDA? □Si □No Lista: _____
6. Liste alérgias: _____
7. Tienes alérgias a neomicina, estreptomicina, geleatina, levadura de pan o huevos/blaquilios? □Si □No
8. Ha tenido una reacción a una vacuna especialmente: ataque, fiebre(de), anafilaxiz, sarpullido, o cambio de estado de mente?
   □Si □No Explique: _____
9. Quantas veces a ido a la sala de emergenica este ultimo año? _____ Razones? (liste): _____
   _____
10. Para las jóvenes, puedes esta embarazada? □Si □No
11. Hay alguna de estras condiciónes médicas en la familia? Ponga la inicial de cada miembro afectado
    (M=madre, P=padre, H=hermana(o), A=abuelo(a), T=tio/tia)

Enfermedad del Corazón _____ Cancer _____ Colesterol Alto _____ Asma _____ Diabetes _____ Alto Presión _____ Convulsiones _____ Sickle Cell _____ Otras Enfermedades _____

CONSENTIMIENTO PARA EL EXAMEN MEDICO Y VACUNACION

Yo _____ doy permiso, a el personal de La Unidad Mobil Pediatrics del Hospital St. Bernard que le hagan un examen a mi niño(a). Yo tambien doy permiso para que comparta este examen fisico con la escuela. Nombre de la escuela _____

Yo he leido o me han explicado la información de las vacunaciones identificadas abajo. Yo reconozco que he estado informado de los peligros y beneficios y he tenido la oportunidad de hacer preguntas que fueron contestadas a mi satisfación. Entiendo los peligros de las vacunas de abajo y pido que vacunen a mi nino(a).

Firma _____ Fecha _____

Nombre en letra molde: _____ Relación _____

A veces, St. Bernard Hospital, toma fotos de ninos para material promocional. Marque aqui_____ si usted no quiere que tomemos fotos de su hojo/a.

Tiene su hijo/a un doctor? Si____ No____

Si no, puede Beloved Community Wellness Center (un centro medico) se comunica con usted acerca de harcerse el doctor de su hijo/a? Si_____ No _____

Para los que viven en Englewood: Tiene asma su hijo/a? Si____ No____

Si respondio si, puede "Addressing Asthma in Englewood" (una organizacion que responde a problemas de asma), se comunica con usted para explicar su programa gratis? Si____ No____

FOR USE IN DCFS LICENSED CHILD CARE FACILITIES
CFS 600
Rev 2/2013

DCFS

State of Illinois
Certificate of Child Health Examination

Student's Name (Last, First, Middle)	Birth Date (Month/Day/Year)	Sex	Race/Ethnicity	School /Grade Level/ID#

Address (Street, City, Zip Code)	Parent/Guardian	Telephone # Home	Work

IMMUNIZATIONS: To be completed by health care provider. Note the mo/da/yr for *every* dose administered. The day and month is required if you cannot determine if the vaccine was given *after* the minimum interval or age. **If a specific vaccine is medically contraindicated, a separate written statement must be attached explaining the medical reason for the contraindication.**

Vaccine / Dose	1 MO DA YR	2 MO DA YR	3 MO DA YR	4 MO DA YR	5 MO DA YR	6 MO DA YR
DTP or DTaP						
Tdap; Td or Pediatric **DT** (Check specific type)	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT	☐Tdap☐Td☐DT
Polio (Check specific type)	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Hepatitis B (HB)						
Varicella (Chickenpox)						
MMR Combined Measles Mumps. Rubella						
Single Antigen Vaccines	**Measles**	**Rubella**	**Mumps**			
Pneumococcal Conjugate						
Other/Specify Meningococcal, Hepatitis A, HPV, Influenza						

COMMENTS:

Health care provider (MD, DO, APN, PA, school health professional, health official) verifying above immunization history must sign below. If adding dates to the above immunization history section, put your initials by date(s) and sign here.)

Signature **Title** **Date**

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis is acceptable if verified by physician. *(All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.)

***MEASLES (Rubeola)** MO DA YR **MUMPS** MO DA YR **VARICELLA** MO DA YR **Physician's Signature**

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below is verifying that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title** **Date**

3. Laboratory confirmation (check one) ☐**Measles** ☐**Mumps** ☐**Rubella** ☐**Hepatitis B** ☐**Varicella**
Lab Results **Date** MO DA YR **(Attach copy of lab result)**

VISION AND HEARING SCREENING BY IDPH CERTIFIED SCREENING TECHNICIAN

Date																							
Age/ Grade																							
	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	R	L	
Vision																							
Hearing																							

Code:
P = Pass
F = Fail
U = Unable to test
R = Referred
G/C = Glasses/Contacts

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY **TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER**

ALLERGIES (Food, drug, insect, other)				**MEDICATION** (List all prescribed or taken on a regular basis.)			
Diagnosis of asthma? Child wakes during night coughing?	Yes Yes	No No		Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Birth defects?	Yes	No		Hospitalizations? When? What for?	Yes	No	
Developmental delay?	Yes	No					
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No		Surgery? (List all.) When? What for?	Yes	No	
Diabetes?	Yes	No		Serious injury or illness?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No		TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
Seizures? What are they like?	Yes	No		TB disease (past or present)?	Yes*	No	
Heart problem/Shortness of breath?	Yes	No		Tobacco use (type, frequency)?	Yes	No	
Heart murmur/High blood pressure?	Yes	No		Alcohol/Drug use?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No		Family history of sudden death before age 50? (Cause?)	Yes	No	
Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor _____. Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)				Dental ☐ Braces ☐ • Bridge ☐ • Plate Other			
Ear/Hearing problems?	Yes	No		Information may be shared with appropriate personnel for health and educational purposes. **Parent/Guardian Signature** **Date**			
Bone/Joint problem/injury/scoliosis?	Yes	No					

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**

HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes ☐ No ☐ **Ethnic Minority** Yes☐ No ☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No ☐ **At Risk** Yes ☐ No ☐

LEAD RISK QUESTIONNAIRE Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)

Questionnaire Administered ? Yes ☐ No ☐ **Blood Test Indicated?** Yes ☐ No ☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. **No test needed** ☐ **Test performed** ☐

Skin Test: Date Read / / **Result: Positive** ☐ **Negative** ☐ **mm** _____

Blood Test: Date Reported / / **Result: Positive** ☐ **Negative** ☐ **Value** _____

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	**Normal**	**Comments/Follow-up/Needs**		**Normal**	**Comments/Follow-up/Needs**
Skin			**Endocrine**		
Ears			**Gastrointestinal**		
Eyes		Amblyopia Yes☐ No☐	**Genito-Urinary**		LMP
Nose			**Neurological**		
Throat			**Musculoskeletal**		
Mouth/Dental			**Spinal Exam**		
Cardiovascular/HTN			**Nutritional status**		
Respiratory		☐ Diagnosis of Asthma	**Mental Health**		
Currently Prescribed Asthma Medication: ☐ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			**Other**		

NEEDS/MODIFICATIONS required in the school setting

DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g. ,seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)

PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Limited** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**

Address **Phone**

(Complete Both Sides)