

**Le Bonheur On the Move: Mobile Medical Unit  
Consent for Medical Examination and Care  
June 201: – July 201;**

Dear Parent/Guardian,

During the year as identified above, your child will have the opportunity to receive annual (or sports) physicals and medical care including sick visits provided by a Le Bonheur provider right at your child's school/community site. The care will be provided on Le Bonheur's state of the art Mobile Medical Unit or at a designated site. There is no need for you to be present when your child is on the mobile unit, but we invite you to be present anytime your child is being seen.

In order for your child to participate in this program, you will need to sign this consent form and complete the information in this booklet. We will be scheduling children for annual (or sports) physicals starting with those that are uninsured or underinsured.

**Children will be seen on the mobile unit regardless of their ability to pay for services provided. Insurance will be filed when available. Please complete all of the information in this booklet to allow us to provide the best care for your child and to bill your insurance provider, if necessary.**

*Please read the following statements related to care provided on the mobile unit.*

**CONSENT TO EVALUATE AND PROVIDE TREATMENT FOR THE CONSENT YEAR AS IDENTIFIED ABOVE**

I give permission for my child to receive a medical examination by a physician or nurse practitioner of Le Bonheur Mobile Medical Unit for the purpose of evaluation and/or treatment of medical conditions as well as routine health maintenance. All medical examinations are overseen by a board certified physician or nurse practitioner. I understand that I must give my consent on this form in order to receive medical evaluation and/or treatment. Medical evaluation includes obtaining test results from blood tests, urine tests, saliva tests, and/or other medical tests as required by the physician or nurse practitioner. According to the guidelines established by the American Academy of Pediatrics, all EPSDT/Wellness exams will be unclothed. A drape/gown will be provided and children will keep on their undergarments. The child's privacy will be protected at all times and two healthcare professionals will be present during the unclothed exam for your child's protection.

**RELEASE OF INFORMATION AND CONSENT FOR FOLLOW-UP**

I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to receive relevant information about my child's health from a doctor's office, clinic, school, or agency from which additional information may need to be gathered. I also authorize release of information about my child's health to a doctor's office, clinic, school, or agency to which he/she may be referred. I give permission for Le Bonheur Mobile Medical Unit clinical and case management staff to contact me by telephone or mail regarding the results of my child's exam, possible care options, tips for improving my child's health, specialist appointments, and/or other health related topics. I give permission for my child to be involved in case management activities (such as individual and group meetings) offered after the initial clinic visit. I authorize Le Bonheur Mobile Medical Unit to leave a message regarding appointment or test at my residence or cell phone. I authorize Le Bonheur Mobile Medical Unit to send appointment reminders or other reminders via text message or automated voice message. It is my responsibility to provide Le Bonheur the most up to date contact information. I authorize for my child to have a photo taken for the electronic medical record. I authorize Le Bonheur to electronically access my prescription history through RX Hub ( a prescription database compiling all prescription history).

**SHARING INFORMATION WITH PARENTS/GUARDIANS**

Le Bonheur Mobile Medical Unit follows state regulations and American Academy of Pediatric guidelines regarding adolescent care, adolescent age of consent for medical care, and parent/guardian notification for medical treatment. Adolescent patients will be encouraged to maintain open communication with parents. However, Le Bonheur Mobile Medical Unit will disclose medical information according to Tennessee state law. Please contact Le Bonheur with any questions about age of consent or release of information.

**DATA COLLECTION**

I understand information about my child's progress may be used by Le Bonheur for data collection and reporting purposes. I understand my child's name will not be used without my permission. Le Bonheur Community Health and Well-Being, Le Bonheur Mobile Medical Unit, and their affiliates are hereby released from all legal liability that may arise from the release of the information or from the publication of data obtained.

**NOTICE OF PRIVACY PROCEDURES (HIPPA)**

I have received a copy of the "Notice of Privacy Procedures" for Le Bonheur, in compliance with HIPAA regulations.

**NOTIFICATION OF GRIEVANCE PROCEDURE**

I understand that if I believe either I or my child has been treated unfairly during the course of this screening because of my gender, race, color, national origin, religion, or disability, I have the right to file a complaint. Such complaints are to be addressed in writing to Le Bonheur, Director of Health Services, 77 Stonebridge Boulevard, Jackson, TN 38305. More information may be obtained by calling Le Bonheur at 731-984-9961.

**CONSENT TO BILL THIRD PARTY PAYOR (INSURANCE)**

I authorize University Le Bonheur Pediatric Specialists, Inc., Le Bonheur Children's Hospital, Le Bonheur Community Health and Well-Being, and or their affiliates, to release any information pertaining to treatment to enable the collection of insurance benefits for the services rendered. Release of information is also authorized to any providers of follow-up medical care.

**I understand and agree that this consent is valid during the consent year as the term identified above unless I cancel it in writing. To the best of my knowledge the information provided is complete and correct. I understand it is my responsibility to inform Le Bonheur and its staff if I or my child/ward, has a change in health, insurance coverage or contact information,**

**For more information, please contact Le Bonheur Mobile Health at:  
731-984-9961 (Direct Line)**

\_\_\_\_\_  
Signature of Parent/Guardian Date

**PARENT/GUARDIAN INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS#: \_\_\_\_\_  
Last First MI

Parent/Guardian Email: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Phone Number for Parent/Guardian: \_\_\_\_\_

**Questions About Your Child's Health Care Provider**

Has your child visited the doctor or health care provider because he/she was sick in the last 12 months?  Yes  No  I don't know.

Reason: \_\_\_\_\_

Who is your child's doctor or health care provider? \_\_\_\_\_ Phone: \_\_\_\_\_

Who is your preferred pharmacy? \_\_\_\_\_ Phone: \_\_\_\_\_

## **Insurance Information**

### **Primary Insurance Information:**

- Private Insurance (Other: \_\_\_\_\_)
- BlueCare (TennCare)
- United Community Health Plan (TennCare)
- Amerigroup (TennCare)
- CoverKids (TennCare)
- My child is uninsured.

Member ID Number: \_\_\_\_\_ Group ID Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_

### **Secondary Insurance Information:**

- Private Insurance (Other: \_\_\_\_\_)
- BlueCare (TennCare)
- United Community Health Plan
- Amerigroup (TennCare)
- CoverKids
- My child is uninsured.

Member ID Number: \_\_\_\_\_ Group ID Number: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_

Policy Holder DOB: \_\_\_\_\_ Policy Holder SS#: \_\_\_\_\_

# Health Questions

Child's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F  
First Middle Last

School: \_\_\_\_\_ Phone Number for Parent/Guardian: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Child's Social Security Number: \_\_\_\_\_  
Mo. Day Year

Address of Child: \_\_\_\_\_  
Street Address P.O. Box City State Zip

Child's Race/Ethnicity:  Black  Hispanic  White  Other:

Primary Language Spoken at Home:  English  Spanish  Other:

## **Child's Medical History** (please mark any of the following medical conditions that apply to your child)

ADHD/ADD  Congenital Heart Disease  Diabetes  Asthma  Kidney Disease  Elevated Blood Pressure

Other Medical Conditions:

Has your child ever required hospitalization?  Yes  No Reason: \_\_\_\_\_ Date \_\_\_\_\_

Has your child had any surgical procedures?  Yes  No Reason: \_\_\_\_\_ Date \_\_\_\_\_

Please list all medications the child is currently taking. <input type="checkbox"/> <b>No Medications</b> Include all prescription and nonprescription medication.
1. _____
2. _____
3. _____
4. _____
5. _____

Please list any allergies your child has. <input type="checkbox"/> <b>No Allergies</b>
1. _____
2. _____
3. _____
4. _____
5. _____

Is your child current on all immunizations and vaccinations?  Yes  No  I don't know.

Is your child having any problems, or are you having any concerns? \_\_\_\_\_

## **Family Medical History** (Please mark any of the following medical conditions that members of your child's family have.)

**Child's Mother:**  Living  deceased

High Cholesterol  High Blood Pressure  Heart Disease  Diabetes  Stroke

Mental Illness  Cancer  Heart Attack (Under the Age of 55)  Other Medical Conditions:

Does the mother take cholesterol medication?  Yes  No

**Child's Father:**  Living  deceased

High Cholesterol  High Blood Pressure  Heart Disease  Diabetes  Stroke

Mental Illness  Cancer  Heart Attack (Under the Age of 55)  Other Medical Conditions:

Does the father take cholesterol medication?  Yes  No

**Child's Grandparent:**  High Cholesterol  High Blood Pressure  Heart Disease  Diabetes  Stroke

Mental Illness  Cancer  Heart Attack (Under the Age of 55)  Other Medical Conditions:

# Ages and Stages Questionnaire Overall Developmental Screening

**Ages: Birth – 5 Years**

Child's Name: \_\_\_\_\_

Child's School: \_\_\_\_\_

Please answer the following questions and explain any details that you feel are important.

<p>1. Do you think your child hears well?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If no, explain:</p>
<p>2. Do you think your child talks like other children her age?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If no, explain:</p>
<p>3. Can you understand most of what your child says?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If no, explain:</p>
<p>4. Do you think your child walks, runs, and climbs like other children his age?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If no, explain:</p>
<p>5. Does either parent have a family history of childhood deafness or hearing impairment?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If yes, explain:</p>
<p>6. Do you have any concerns about your child's vision?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If yes, explain:</p>
<p>7. Has your child had any medical problems in the last several months?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If yes, explain:</p>
<p>8. Does anything about your child worry you?</p>	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<p>If yes, explain:</p>

# Pediatric Symptom Questionnaire Checklist 17 (PSC-17)

**Ages: 6 – 20 Years**

Child's Name: \_\_\_\_\_

Child's School: \_\_\_\_\_

Emotional and physical health go together in children. Because parents are often the first to notice a problem with their child's behavior, emotions, or learning, you may help your child get the best care possible by answering these questions.

***Please mark under the heading that best describes your child:***

	Never	Sometimes	Often
* Fidgety, unable to sit still.			
<input type="checkbox"/> Feels sad, unhappy			
* Daydreams too much			
● Refuses to share			
● Does not understand other people's feelings			
<input type="checkbox"/> Feels hopeless			
* Has trouble concentrating			
● Fights with other children			
<input type="checkbox"/> Is down on him or herself			
● Blames others for his or her troubles			
<input type="checkbox"/> Seems to be having less fun			
● Does not listen to rules			
* Acts as if driven by a motor			
● Teases others			
<input type="checkbox"/> Worries a lot			
● Takes things that do not belong to him or her			
* Distracted easily			

Do you have any concerns regarding your child's behavior, emotions, or learning? \_\_\_\_\_

<b>OFFICE USE ONLY</b>			
Total ( * ) _____	Total ( ● ) _____	Total ( □ ) _____	* + ● + □ = _____

**If your child has asthma, please complete the following section:**

**Questionnaire for Patients with Asthma**

Child's Name: \_\_\_\_\_

Child's School: \_\_\_\_\_

*Please answer the following questions about your child's asthma symptoms:*

Has your child been diagnosed with asthma by a nurse practitioner or doctor? If Yes, when:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your child been having asthma symptoms this week?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does anyone smoke inside your home?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you think your child uses tobacco products?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have any exercise or activity limitations due to asthma?	<input type="checkbox"/> none <input type="checkbox"/> minor limitations <input type="checkbox"/> some limitations <input type="checkbox"/> extremely limited
Has your child been prescribed an asthma controller medication? (ex. Pulmocort, Singulair, Flovent, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is your child using the asthma controller medication? If not, why? (ex. Pulmicort, Singulair, Flovent, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many times per week did your child use a <b>rescue medication</b> in the past <u>4 weeks</u> ? (ex. Albuterol, inhaler, etc.)	<input type="checkbox"/> ≤ 2 days/week <input type="checkbox"/> > 2 days/week <input type="checkbox"/> > 1 time/day
How often did the patient have <b>daytime</b> asthma symptoms for the past <u>4 weeks</u> ?	<input type="checkbox"/> ≤ 2 days/week <input type="checkbox"/> > 2 days/week <input type="checkbox"/> daily <input type="checkbox"/> > 1 time/day
How often did the patient <b>awake at night</b> with asthma symptoms this past <u>4 weeks</u> ?	<input type="checkbox"/> 0 nights/month <input type="checkbox"/> 1-2 nights/month <input type="checkbox"/> 3-4 nights/month <input type="checkbox"/> > 1 night/week
How many times in the past <u>12 months</u> has the patient had to take oral steroids?	
Has your child seen a provider for asthma symptoms during the past <u>12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No  # of Visits:
Has your child visited the emergency room for asthma symptoms during the past <u>12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No  # of Visits:
Has your child missed school for asthma symptoms during the past <u>12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No  # of Days:
Has your child been admitted to the hospital for asthma symptoms during the past <u>12 months</u> ?	<input type="checkbox"/> Yes <input type="checkbox"/> No  # of Times:

## Risk Assessment Information

<b>Lead Screening</b>	<b>Yes</b>	<b>No</b>
Have you ever been told your child has an elevated blood lead level?		
Does your child live in or regularly visit a house/school/child care facility built before 1978 that has recently been renovated?		
Does your child live in or regularly visit a house/school/child care facility built before 1950?		
Have you ever seen your child eating paint chips or other non-food substances such as paper?		

<b>Tuberculosis Screening</b>	<b>Yes</b>	<b>No</b>
Was your child born in a country that is at high risk for tuberculosis (other than the US)?		
Has your child traveled outside the USA? If so, Where? _____		
Has your child been around someone who has been in jail or a shelter?		
Has your child been exposed to anyone with TB or a positive TB skin test?		
Is your child infected with HIV?		

<b>Tobacco Use Screening</b>	<b>Yes</b>	<b>No</b>
Is your child exposed to second-hand tobacco smoke?		

<b>Dental Screening</b>	<b>Yes</b>	<b>No</b>
Does the Parent/Guardian of child have dental decay or gum disease?		
Does the Parent/Guardian of child see a dentist regularly?		

<b>Hunger/Anemia</b>	<b>Often</b>	<b>Sometimes</b>	<b>Never</b>
Within the past 12 months, we worried whether our food would run out before we got money to buy more.			
Within the past 12 months, the food we bought just did not last and we did not have money to get more.			
Does your child's diet include iron-rich foods such as meat, eggs, iron-fortified cereals and beans?			