Advocate Children's Hospital

CHICAGOLAND & NORTHWEST INDIANA
RONALD MCDONALD HOUSE CHARITIES

Ronald McDonald Care Mobile

Patient Demographic Information and Patient Agreements & Authorizations Form **General Patient Information**

Child's Full Name	Child's Date of Birth Child's Age	Child's Sex □ Male □ Female
Child's Address	City/State	Zip Code
Child's School Child's Grade	Child's Race (mark all that apply) □ African-American □ Caucasian □ Asian □ Hispanic □ Other _____	Child's Preferred Language
Parent/Legal Guardian's Full Name	Best Daytime Contact Number	

Doctor/Insurance Information

Child's **Regular/Primary doctor**	Doctor's Address	Doctor's Phone Number
Which type of insurance does your child have (please circle)? Medicaid/Public Insurance No Insurance Private Insurance (PPO/HMO) Medicaid ID Number: _____		Doctor's Fax Number □ child does NOT have a PCP

Immunization Information

Please list any immunizations REQUIRED by your school you do NOT want your child to receive
Our team, along with the American Academy of Pediatrics, RECOMMENDS additional immunizations important for your child's health. Please circle which you do NOT want your child to receive HPV Vaccines (age 11 and older) Flu vaccine (seasonal) Hepatitis A vaccine

May your child receive free healthy snack items (may contain nuts, soy, dairy, egg or gluten)? □ Yes □ No

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION:

- I authorize/allow the use and disclosure of this personal health information (PHI) for the purposes of diagnosing or providing treatment to my child, obtaining payment for care, or for health care business management of Advocate Children's Hospital/Advocate Medical Group ("Advocate").
- I authorize/allow Advocate to release information which may be required in the process of applications for financial assistance or insurance coverage for services rendered. This authorization provides that Advocate may release specific clinical information related to my child's diagnoses and treatment, which may be requested by an insurance company or its representative.
- I authorize Advocate to provide my child's educational institution/school with a copy of the health exam, including immunizations administered. I authorize Advocate to release information from the visit to the primary health care provider/doctor named above.

DISCLAIMER: This Ronald McDonald Care Mobile is made possible by a grant from the Ronald McDonald House Charities, Inc. ("RMHC"), a non-profit, tax-exempt charitable corporation. RMHC has no responsibility or liability for the operation of this Ronald McDonald Care Mobile or any of the medical or dental activities conducted herein.

CONSENT FOR TREATMENT: I do consent/permit to the treatment provided by Advocate Physicians, Nurses or other designated health care providers. I understand that Physicians, Nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in my child's treatment and I consent/permit to such health care provider in training involvement. This treatment can include physical examination, health screenings and all recommended and required immunizations except where declined above.

I hereby release, discharge and hold harmless Advocate Health and Hospitals Corporation, d/b/a Advocate Children's Hospital and its parent companies, subsidiaries, affiliates, predecessors, successors and assigns, agents, shareholders, and employees (both past and present) of and from all liability, claims or demands arising out of or related to any loss, damage or injury, including death, to my child from any cause whatsoever, including negligence, that may arise from or otherwise be related to my child's participation and treatment provided in the Ronald McDonald Care Mobile program. This release is binding on my heirs, executors, administrators, assigns, agents, attorneys and representatives.

My signature below constitutes my acknowledgement and agreement that I have read and understand all the provisions of this release, and sign this as a free and voluntary act. I was given an opportunity to discuss this form and ask questions, and that all questions were answered to my satisfaction.

Parent/Legal Representative Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Certificate of Interpretation

I certify that I have interpreted the forgoing to the signor hereof in the _____ language.

Date: _____ Time: _____ Interpreter Signature: _____

_____	_____
Date:	Parent/Guardian's Signature
_____	_____
Date:	Witness's Signature: