HEALTHY KIDS EXPRESS CONSENT AND MEDICAL HISTORY FORM

Please complete a form for each child and return to his/her program

CHILD'S NAME LAST FIRST MIDDLE INITIAL ☐ MALE ☐ FEMALE DATE OF BIRTH

SCHOOL GRADE/AGE

RACE (optional-check all that apply):

☐ American Indian/Alaskan Native ☐ Asian ☐ Bi or Multi-Racial ☐ Black/African American ☐ Middle Eastern
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Unknown ☐ Other _____ ☐ Decline to Answer

ETHNICITY: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Unknown ☐ Decline to Answer

PARENT/GUARDIAN NAME LANGUAGE SPOKEN IN HOME PREFERRED WRITTEN LANGUAGE

HOME ADDRESS STREET APT # CITY STATE ZIP CODE

HOME PHONE (INCLUDE AREA CODE) CELL/PAGER WORK PHONE EMAIL ADDRESS (optional)

NAME OF EMERGENCY CONTACT CELL/HOME PHONE WORK PHONE RELATIONSHIP TO CHILD

NAME OF DOCTOR/CLINIC PHONE NAME OF DENTIST/CLINIC PHONE

DOES YOUR CHILD HAVE HEALTH INSURANCE: ☐ NO ☐ YES...NAME OF INSURANCE PROVIDER: _____

DOES YOUR CHILD RECEIVE FREE OR REDUCED SCHOOL LUNCH: ☐ NO ☐ YES

I have read and understand the nature of the screening services offered to my child and have completed all blanks and/or sought answers to my questions (if any) related to the screenings. I authorize and consent for my child to participate in the indicated screening(s) by my signature below.

PARENT/GUARDIAN SIGNATURE **DATE** [CONSENT IS VALID FOR ONE YEAR]

IF YOU ***DO NOT*** WANT SCREENINGS FOR YOUR CHILD, PLEASE CHECK THIS BOX. ☐ *[No signature needed]*

PLEASE CHECK THE SCREENING SERVICES YOU WOULD LIKE FOR YOUR CHILD:

☐ **HEARING** ☐ **VISION** ☐ **DENTAL EXAM*** with fluoride varnish if applicable (3 years and up)
☐ **LEAD**** (2-5 years) ☐ **ANEMIA**** (Low iron) ☐ **CHOLESTEROL/GLUCOSE testing**

*** For Dental - PERMISSION TO GIVE IBUPROFEN** ☐ Yes ☐ No

**** For Lead and Anemia: Blood may need to be drawn from your child's vein if the finger stick results are abnormal. The results from the blood draw may be shared with the Department of Health and your child's primary care provider.**

NOTE: Release is not required for your child to obtain a screening but assists in coordinating care/treatment of your child with other providers

MEDICAL HISTORY - PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING:

☐ ANEMIC (Low iron in blood) ☐ EYE PROBLEMS/SURGERY ☐ FREQUENT EAR INFECTIONS ☐ ASTHMA ☐ CONGENITAL HEART DEFECT
☐ LEAD (History of high levels) ☐ WEARS GLASSES ☐ EAR SURGERY (TUBES PLACED) ☐ HIV/AIDS ☐ MENTAL/PHYSICAL DISABILITY
☐ HIGH BLOOD PRESSURE ☐ SICKLE CELL DISEASE ☐ HEARING PROBLEMS/HEARING AIDS ☐ BLEEDING DISORDER ☐ PREGNANT
☐ **NONE OF THE ABOVE** ☐ OTHER: _____

PLEASE EXPLAIN ANY ITEM CHECKED ABOVE: _____

HOSPITALIZATIONS: _____ SURGERIES: _____

LIST ANY MEDICATIONS YOUR CHILD TAKES: _____

LIST ANY ALLERGIES YOUR CHILD HAS: ☐ LATEX ☐ SEASONAL ☐ FOOD: _____ ☐ DRUG: _____

PLEASE LIST ADDITIONAL CONCERNS YOU MAY HAVE ABOUT YOUR CHILD: _____

Dear Parent:

St. Louis Children's Hospital's ***Healthy Kids Express*** is a mobile health van that provides free health screenings to children. We will be coming soon to your child's school, community or child care organization. Our goal is to identify possible health concerns or conditions as early as possible, when treatment may be most effective.

Our routine health screenings include tests for hearing and vision.
Services offered on a limited basis include:

- lead and anemia blood testing
- dental screens, cleanings and flouride varnish

Parents are always welcome during the child's health screening.

To help us provide screenings for your child, we need you to complete and sign this health questionnaire and consent form and return it to your child's program.

Please read and initial

1. Release of Information (below)
2. Privacy Practices (back cover)

Because health screenings may show a need for additional care or monitoring, we will share all findings with your child's primary care provider and the enrollment location. As an additional benefit, our team can assist you in accessing other community resources. You may opt out of this additional service at any time through any HKE representative.

Please contact us if you have questions: 314.286.0947 or HealthyKidsExpress@bjc.org.

Release of Information

Release of information is not required for your child to be screened. To assist in any care needs for your child, we will forward your child's screening as directed below.

I consent to the St. Louis Children's Hospital Healthy Kids Express use, storage and release of my child's screening records, either electronically or otherwise, created or received by Healthy Kids Express for my child's care and treatment as permitted by law, and specifically to release screening information to the doctor listed in this consent and/or the school involved or who may be involved in my child's care.

Parent/Guardian please initial: _____

All services are FREE on Healthy kids Express®

Privacy Practices

St. Louis Children's Hospital respects the privacy of your child's health information. To explain how we protect your child's health information, please read the summary of our notice of privacy practices that is printed in this brochure on the back side of the parent letter. If you would like to obtain a copy of our notice, please call us at 314-286-0927 or ask your child's program or the ***Healthy Kids Express*** staff for a copy.

My initials below acknowledge that I have been given an opportunity to receive St. Louis Children's Hospital's Notice of Privacy Practices.

Parent/Guardian please initial: _____

This program is made possible by generous donations to the St. Louis Children's Hospital Foundation.

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St. Louis, Missouri 63110

314.286.0947 / 314.286.0960 fax

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