KDOW Updated Consent Form:

Please complete all information on this permission form. Please **COMPLETE USING INK** then sign and date it in order for your child to continue services from Kids'-Doc-On-Wheels, Inc. Please notify us immediately of any changes in address, phone numbers and/or insurance.

Date:_____________Patient's Name:____________________________________ ______________________________ __________________
Last **First** **Middle**

Address:____ Apt.#:_____ City:________________________ State:_________ Zip: ____________

(Office Use Only) Address update:____

Home Phone#:______________ Mother's Work Phone#:_______________ Father's Work Phone#:_______________ Cell #:_________________

(Office Use Only) Additional #'s: Date/Name _______________________________________ ______________________________

Emergency Name & Number:____ Relationship to Patient:____________________________

Birth Date: _______________ Birth Country: USA Other ________________ Primary Language: English Other _________________

If other, Please specify *If other, Please specify*

Social Security Number: ___________________________ Sex (circle one): Male Female

School:___________________________________ Grade: __________ Remedial/Special Education: Yes No

***Pharmacy Name and Address:** _________________________________ **Pharmacy Number:** _____________________________________

Insurance Information:

Medicaid#_______________________________________

Private Company Name:____________________________________ Policy #:_____________________Group #:___________________

Address____

No Insurance

(You may be eligible for Medicaid if not currently receiving it. Would you be interested in someone contacting you regarding this insurance? Yes No

Updated Health Information:

Any new **Medical Conditions (physical, behavioral health, dental)**: Yes No
If Yes, please list:____

Any new **Allergies (medications, food, environmental)**: Yes No
If Yes, please list:____

Is your child currently being seen for Behavior Health or Mental Health? Yes No
If yes, who is the Provider: ______________________________

Dental Appointment in the past year: Yes No If Yes, Date Seen:_________________________

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I hereby give consent for my child to continue to receive medical, behavioral health and dental services (when available) from _________________________________Kids'-Doc-On-Wheels, Inc. I authorize any physician, physician-designated health professional, dentist or behavioral health provider working for the clinic to provide such medical tests, procedures, treatments and assessments as are reasonably necessary or advisable for the evaluation and management of my child's health care.

Name of Parent or Legal Guardian (Please Print) **Signature of Parent/Legal Guardian** **Date**

____ ____ _______________________

Name of Patient (Please Print) **Relationship to Patient**

____ ____

Photo Release

By signing below, I hereby grant Kids'-Doc-On-Wheels, Inc. the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all pictures of me or my child publicly to be used in and or for any lawful promotional materials including, but notlimited to, newsletters, flyer's, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social networking sites and other print and digital communications without payment or any other consideration. I understand that photos for distribution will not take place at any time during my child's physical examination. I understand that no royalty, fee or other compensation shall become payable to me by reason of such use. I waive any right to royalties or other compensation arising or related to the use of the photograph. I understand and agree that these materials shall become the property of Kids'-Doc-On-Wheels, Inc. and will not be returned.

Yes, I consent to photos. Signature: ______________________________ **-or- No, I do not consent to photos. Signature:** ______________________________