Mesa Pediatrics
Professional Association

Consent by Proxy for Non Urgent Pediatric Care

Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____
Patient Name: _____ DOB: _____

I (we) appoint as our proxy decision maker:
Name: _____Relationship to patient: _____
Name: _____Relationship to patient: _____
Name: _____Relationship to patient: _____

The person named above has my permission to consent to non-urgent medical care for my (our) children listed on this document. I (we) have the legal right to delegate consent to the proxy decision maker, who is an adult and legally and medically competent to exercise the authority delegated. Be advised that protected patient healthcare information may be shared with the proxy to facilitate informed consent.

Limitations

Identify any limitations for medical services which this consent by proxy is given. If none, state "none".

_____
_____
_____

Contact Information

If the nature of the medical care is not routine, please contact me (us) regarding the health care of my (our) children at the following telephone number(s). If you are unable to contact me (us), you may rely on the proxy decision maker for consent.

Parents Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

_____
Parent or Legal Guardian Signature

_____
Date

Parents Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

_____
Parent or Legal Guardian Signature

_____
Date

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MPPA Health History

Date: _____

Patient Name: _____ **Date of Birth:** _____ **Gender:** ☐ Female ☐ Male

A. Child's Birth History

Illnesses during pregnancy? Y N _____

_____

Medications taken during pregnancy? Y N _____

_____

Group B strep positive? Y N

Antibiotics during delivery? Y N If yes, number of doses: _____

Where was your baby born? _____

Referring OB/Doctor? _____

Baby's gestational age: _____ weeks _____ days

Delivery: ☐ Vaginal ☐ C-Section - Reason for C-Section _____

Birth Weight: _____ lbs _____ oz Birth Length: _____ inches

Age at discharge from hospital: _____

Complications during hospitalization: Y N _____

_____

Was your baby:

Jaundiced: Y N how long? _____

Breast fed: Y N how long? _____

Formula fed: Y N how long? _____

Which formula? _____

Did your baby receive:

Vitamin K shot? Y N Erythromycin eye ointment? Y N

Hepatitis B vaccine in the hospital? Y N

If yes, date vaccine received: _____

Pass the hearing screen? Y N

B. Child's Past Medical History

1. Hospitalizations/Major Illnesses or Major Injuries/Surgeries

Year	Major Illness/Injury/Surgery	Hospital if required

Does your child have allergic reactions to: Medicines Y N

Foods: Y N Other: Y N Describe: _____

Does your child take any daily or seasonal medications? Y N ?

Describe: _____

Are your child's vaccinations up to date? Y N ?

2. Illnesses

Has your child ever had the following?

Abdominal pain	Y	N	?
ADHD	Y	N	?
Allergic rhinitis	Y	N	?
Allergies	Y	N	?
Anemia	Y	N	?
Asthma / wheezing	Y	N	?
Autism	Y	N	?
Bleeding disorder	Y	N	?
Blood transfusions	Y	N	?
Chickenpox	Y	N	?
Congenital deformity	Y	N	?
Congenital heart disease	Y	N	?
Constipation	Y	N	?
Cystic fibrosis	Y	N	?
Developmental delay	Y	N	?
Diabetes mellitus	Y	N	?
Eczema	Y	N	?
Epilepsy	Y	N	?
Failure to thrive	Y	N	?
Febrile seizures	Y	N	?
Headache	Y	N	?
Hearing problems	Y	N	?
Heart murmur	Y	N	?
Hepatitis	Y	N	?
Hyperthyroidism	Y	N	?
Hypothyroidism	Y	N	?
Jaundice - history of	Y	N	?
Learning problem	Y	N	?
Migraine	Y	N	?
Pneumonia	Y	N	?
Prematurity - history of	Y	N	?
Recurrent ear infections	Y	N	?
Seizures / epilepsy	Y	N	?
Speech delay	Y	N	?
Vision problems	Y	N	?
Whooping cough	Y	N	?

C. Developmental History

Milestones	Age Achieved	Milestones	Age Achieved
Rolled Over		Walked	
Sat alone		Spoke first words	
Crawled		Used sentences	
Stood alone		Toilet trained	

over »

Health History Continued

Patient Name: _____ **Date of Birth:** _____

D. Family History

Relation	Age	Health Condition
Father		
Mother		
Brothers		
Sisters		

Have any of your child's blood relatives had any of the following conditions?

Medical Condition		Relation to child
AIDS	Y N ?	
Arthritis, gout	Y N ?	
Asthma	Y N ?	
Birth defects	Y N ?	
Bleeding disorders	Y N ?	
Cancer	Y N ?	
Cystic fibrosis	Y N ?	
Diabetes	Y N ?	
Epilepsy / seizures	Y N ?	
Heart Disease	Y N ?	
Hepatitis	Y N ?	
Hypertension	Y N ?	
Kidney Disease	Y N ?	
Mental Illness	Y N ?	
Muscular dystrophy	Y N ?	
Obesity	Y N ?	
Tuberculosis	Y N ?	
Other	Y N ?	

E. Social History

Are there any cigarette smokers in the home?	Y N	
Are there any pets in the home?	Y N	Please list:: _____
How many people live in the home?	1 2 3 4 5 6 7 8	Please list:: _____
Does your child attend daycare?	Y N	Describe: _____
Preschool?	Y N	
School?	Y N	Grade Level: _____

F. Additional Information

Signature: _____

Relation to patient: _____

Reviewed by / date: _____

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MPPA REVIEW OF SYSTEMS

Date_____

Patient Name: _____

Date of birth: _____

Please review the following list and check those that your child has complained about or suffered from in the past year. Mark **Y** if your child has experienced a problem, **N** if not. Depending on the age of your child some of these questions may not apply. If so, please mark **NA**.

GENERAL

Chills	Y	N	N
Fever	Y	N	N
Persistently Tired	Y	N	N
Sweats	Y	N	N
Loss of Weight	Y	N	N

SKIN

Acne	Y	N	N
Eczema	Y	N	N
Slow healing bruises	Y	N	N
Changing mole	Y	N	N
Excessive sweating	Y	N	N
Hives	Y	N	N
Persistent rashes	Y	N	N

HEAD,EYE,EAR,NOSE,THROAT

Vision problems	Y	N	N
Excessive tearing	Y	N	N
Loss of hearing	Y	N	N
Ear discharge	Y	N	N
Frequent ear infections	Y	N	N
Earache	Y	N	N
Frequent nosebleeds	Y	N	N
Nasal congestion	Y	N	N
Mouth breathing	Y	N	N
Snoring	Y	N	N
Allergies	Y	N	N
Sinus problems	Y	N	N
Bleeding gums	Y	N	N
Hoarseness	Y	N	N
Sores in mouth/gums	Y	N	N
Dental problems	Y	N	N
Been to dentist	Y	N	N
Frequent tonsil infections	Y	N	N
Difficulty talking	Y	N	N
Stuttering	Y	N	N

RESPIRATORY

Night-time cough	Y	N	N
Recurrent/chronic cough	Y	N	N
Shortness of breath	Y	N	N
Unable to keep up with peers	Y	N	N
Difficulty breathing	Y	N	N
Wheezing	Y	N	N

CARDIOVASCULAR

Chest pain	Y	N	N
Heart murmur	Y	N	N
Irregular heart beat	Y	N	N
Hypertension	Y	N	N
Difficulty breathing lying down	Y	N	N

GASTROINTESTINAL

Food restriction/dieting	Y	N	N
Stomach aches	Y	N	N
Dark stools	Y	N	N
Bloody stools	Y	N	N
Constipation	Y	N	N
Diarrhea	Y	N	N
Nausea	Y	N	N
Vomiting	Y	N	N

GENITOURINARY

Unusual urine odor	Y	N	N
Blood in urine	Y	N	N
Discharge from vagina or penis	Y	N	N
Frequent urination	Y	N	N
Painful urination	Y	N	N
Bed-wetting problems	Y	N	N

MUSCULOSKELETAL

Prior fracture	Y	N	N
Scoliosis	Y	N	N
Back Pain	Y	N	N
Painful joints	Y	N	N
Swollen joints	Y	N	N

NERVOUS SYSTEM

Speech / gait problems	Y	N	N
Dizzy	Y	N	N
Fainting spells	Y	N	N
Headaches	Y	N	N
Seizures	Y	N	N
Tremors	Y	N	N
Weakness	Y	N	N

PSYCHIATRIC

Anxiety	Y	N	N
Change in sleep pattern	Y	N	N
Depression	Y	N	N
Inability to concentrate	Y	N	N

ENDOCRINE

Appetite change	Y	N	N
Cold intolerance	Y	N	N
Excessive thirst	Y	N	N
Excessive urination	Y	N	N
Heat intolerance	Y	N	N

HEMATOLOGIC

Abnormal bleeding	Y	N	N
Easy bruising	Y	N	N
Nose bleeds	Y	N	N

Reviewed by / Date_____

Form Revised 5/25/05

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Mesa Pediatrics Vaccine Refusal Policy

Date: _____

Patient Name: _____ D.O.B.: _____

Mesa Pediatrics remains committed to the continuing pursuit of excellence in pediatric medicine, which includes preventive care. Our providers strongly believe in the use of childhood vaccinations to prevent serious medical diseases and in some cases, even death. We also believe in the safety of all of our patients, which at times includes young infants who are not yet eligible to receive these important vaccines.

For these reasons, starting June 1st, 2015, Mesa Pediatrics will no longer be accepting new patients who choose to defer all vaccinations for their children.

If you have questions regarding this policy, please do not hesitate to ask your provider.

I have read and understand Mesa Pediatrics Vaccine Refusal Policy. I am the parent of said minor child, or the court appointed guardian for the patient, and am authorized to act on the patient's behalf.

_____ _____

Parent / Guardian Signature Print Name