Certificate of Child Health Examination

If your child needs a health history form filled out by their provider, please complete the request form below. If the request is for a State of Illinois Child Medical Examination form, Town & Country Pediatrics can provide it for you. All other program specific forms should be provided by you. Please remember to complete the parent and allergy portion before returning the State of Illinois Child Medical Examination health form to your school/day care.

If your child has not been seen within the last 12 months for a check-up, you will be asked to complete a visit before the form can be finished.

Please allow Town & Country Pediatrics up to 10 business days to complete your child's form.

Please complete the information below, sign and date where indicated. Your signature represents that you are the legal parent or guardian of the minor child who is Town & Country Pediatrics patient. You therefore act as the minor child's personal representative as HIPAA defines that term. That means that you may have access to the minor child's Protected Health Information. You agree to notify Town & Country Pediatrics if your status as the minor child's personal representative changes for any reason. In unusual circumstances HIPAA may prohibit Town & Country Pediatrics from continuing to provide you with such access to the minor child's Protected Health Information. If those unusual circumstances ever arise, then Town & Country Pediatrics will explain why.

Please provide the following information:

PATIENT INFORMATION	**TODAY'S DATE:**
Last Name:	First Name:
Gender: ☐ Male ☐ Female	DOB:

PARENT/GUARDIAN		
Last Name:	First Name:	
Address:		
City:	State:	Zip:
Home Telephone #:	Cell Phone #:	

DELIVERY METHOD			
☐ **Pick Up** *(Select location below)*	☐ **Mail** *(Enter Mailing Address below)*	☐ **Email *** *(Enter Email Address below)*	
Pick Up Location:	☐ Halsted Location	☐ Lincoln Avenue Location	☐ Glenview Location
Mailing Address:			
Email Address:			

NAME OF PERSONAL REPRESENTATIVE: _____

SIGNATURE OF PERSONAL REPRESENTATIVE: _____

RELATIONSHIP: _____ **DATE:** _____ **TIME:** _____

*****By checking this box, I agree to receive email communication that may contain protected health information. I understand that email transmissions cannot be guaranteed to be delivered, secured or error-free despite best efforts of sender. Sender does not accept liability for errors resulting from transmission.

Halsted
1460 N. Halsted Street
Suite 402
Chicago, IL 60642
312.279.8900 *Office*
312.981.6312 *Fax*
tcpofficehalsted@luriechildrens.org

Lincoln
6374 N. Lincoln Avenue
Suite 204
Chicago, IL 60659
773.478.1067 *Office*
773.478.4916 *Fax*
tcpofficelinc@luriechildrens.org

Glenview
2601 Compass Road
Suite 120
Glenview, IL 60026
847.998.8806 *Office*
847.998.8807 *Fax*
tcpofficeglen@luriechildrens.org