



Auburn Campus
 "A School Based Health Center"

Crusader Community Health in collaboration with RPS 205 is pleased to offer health services to students at the Auburn High School site. If you would like your child to receive medical, dental, optical and mental health services at the health center, please complete and sign the attached consent forms and return them to the health center or to the school nurse at your child's school.

The goal of the health center is to improve the physical and emotional health of students and teach them life-long positive health behaviors. The health center will be open Monday-Friday 8:30am to 5pm.

Crusader Community Health will bill to private insurance and Medicaid (AllKids). **No child will be denied services due to the inability to pay.**

- Consent to Release form: Allows us to share appropriate information with RPS 205 and transport your child.
- Consent for Treatment: Allows Crusader Community Health to perform the services your child needs.
- Medical History form: Lists details and information the doctor or dentist may need to know about your child
- Registration Form: This is your child's personal and billing information.

After you sign and return these forms your child will be able obtain services provided at the health center which include:

Medical Services	Behavioral Health Services	Health Education
<ul style="list-style-type: none"> ▪ Physical examinations including sports and school physicals ▪ Immunizations ▪ Diagnosis/treatment of acute illness and injury ▪ Diagnosis/management of chronic conditions ▪ Prescribing/dispensing medications for common illnesses and disorders <ul style="list-style-type: none"> ➢ Tylenol, Advil or other over-the-counter pain relievers with parental consent ➢ Antibiotics as prescribed ▪ Behavioral risk assessments ▪ Nutrition counseling and education ▪ Reproductive health services including: <ul style="list-style-type: none"> ➢ abstinence counseling ➢ diagnosis/treatment of sexually transmitted infections ➢ pregnancy testing ➢ contraceptive counseling/exams/prescription ▪ Basic lab tests <ul style="list-style-type: none"> ➢ Strep test ➢ Hemoglobin test 	<ul style="list-style-type: none"> ▪ Crisis intervention and linkage to appropriate crisis intervention services if needed ▪ Behavioral Health services including: <ul style="list-style-type: none"> ➢ Screening for potential substance abuse/mental health services ➢ Provide brief intervention to address concerns, impart education, and need for continued services ➢ Provide direct referrals to services that include specific providers and appointment 	<ul style="list-style-type: none"> ▪ Individual health education and anticipatory guidance for students and parents ▪ Group education ▪ Family and community education ▪ Health education for school based health center and school staff ▪ Support for comprehensive health education in the classroom ▪ Nutrition counseling and education
		Dental Services
	<ul style="list-style-type: none"> ▪ Exams/cleanings ▪ Restorative (fillings, stainless steel crowns) ▪ Extractions ▪ Emergency care for pain 	<ul style="list-style-type: none"> ▪ Exams, eyeglasses and contacts ▪ Treatment and management of ocular disease ▪ Emergency treatment for ocular injury, redness and pain ▪ Vision therapy services

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully!

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes: A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes: We submit a request for payment to your health insurance company. The health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations: We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

Your Health Information Rights

The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if your amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will not include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact **Crusader Community Health** in person or in writing, during normal hours. We will provide you with assistance on the steps to take to exercise your rights.

Our Responsibilities The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of this Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Crusader Community Health**. Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Crusader Community Health**. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary.

Other Disclosures and Uses

Notification Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.

Food and Drug Administration (FDA) We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect: We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement: We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Child's Name: _____, _____, _____ Child's Date of Birth: ____/____/____
(Last) (First) (MI)

**CONSENT TO RELEASE OF INFORMATION,
CONFIDENTIALITY & PRIVACY, ASSIGNMENT OF BENEFITS
CONSENT TO TREAT AND TRANSPORT**

Crusader Community Health (Service Organization) has partnered with Rockford Public Schools, District No. 205 to provide medical, dental, optical and mental health services to District 205 students. I understand I am providing this Consent for the purpose of obtaining professional services for my child listed below and for the other purposes described in this Consent. I further understand this Consent covers medical, dental, optical and mental health services provided by the Service Organizations.

Acknowledgement of Release Of Information

- By signing this consent, I authorize the Service Organizations, their individual service providers their supervisors and District No. 205 to exchange and discuss appropriate information pertaining to my child only when needed for my child's treatment.
- I also authorize the Service Organizations to communicate with my child's regular primary care provider and/or dentist.

Emergency Consent/Changes In Health Status Or Custody

- I understand that as a condition of this Consent, if any of the Service Organizations judge my child to be a serious danger to him/herself or others, then the Service Organization(s) reserves the right to inform a physician, others who may be at risk, designated emergency contacts and appropriate emergency services. I further agree that I will promptly inform the School Based Health Center staff in writing of **1)** any change in my child's physical or medical health and **2)** any change in the custody or guardianship of my child which affects my ability to provide this Consent on behalf of my child.

Confidentiality & Privacy

- I understand the Service Organizations will protect the privacy of my child's health and educational records to the extent required by federal and state law. I understand that I may revoke this authorization at any time (except to the extent that any Service Organization has already taken action based upon my prior consent) if I make a written statement revoking the authorization and deliver it to Crusader Community Health-Auburn Campus 1002 N. Pierpont Ave. Rockford, IL 61101

Assignment Of Benefits

- I hereby assign to the Service Organizations any and all payments to which I am entitled under Medicaid or any health insurance policy for health care or dental health services rendered to my child by any Service Organization as long as the charges for services by the Service Organization (s) do not exceed the Service Organization's regular charges. I further authorize each Service Organization to bill and receive payment directly from Medicaid or my insurance carrier (s) for those services that the Service Organization delivered and for which I may be entitled to insurance coverage. I also authorize each Service Organization to give to Medicaid or my health insurance carrier (s) any information necessary for billing purposes for services provided for such periods of time as my child has received or is receiving primary health care or dental health services.

Initials _____

Child's Name: _____, _____, _____ Child's Date of Birth: ____/____/____
(Last) (First) (MI)



Authorization for Treatment/Transportation

Services are provided by Crusader Community Health, Rosecrance and Primary Eye. District No. 205 will transport eligible students to and from District No. 205 schools and the School Based Health Center.

- If my child needs transportation as indicated below, I consent to having District No. 205 transport my child to and from the School Based Health Center for services, at no cost to me.
- If my child is being seen at the health center after schools hours I am responsible for making transportation arrangements for my child. Crusader Community Health will not be responsible for transportation of students.
- I hereby authorize the Service Organization and clinic staff to administer medical, dental, optical and mental health treatment and procedures including immunizations as well as any other care or treatment which is indicated in urgent situations or emergencies, without the need to secure permission or consent from me or my relatives. I understand that treatment will be provided to my child by a provider and whomever he or she selects as assistants, whomever he or she may call as consultants, as well as clinic employees (nurses, technicians, aides, and other health care personnel) under the direction of the provider, or other individuals under the supervision of the provider.
- I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from such medical/dental treatment.
- I consent to the disposal by Crusader Community Health of any tissues or parts that may be removed.
- I authorize the Service Organization and its staff to release immunization information to the ICARE for the purposes of record completion and community/county tracking.
- I _____ have read the above material and understand its meaning. My signature below indicates my permission for my child to participate in the student travel/activity described above as well as my agreement to the terms set forth above. My signature also indicates that I have read and approve the medical treatment authorization and attest to the accuracy of the information provided on both sides of this form.

Print Parent Name: _____ Signature of Parent/Guardian: _____

Date: _____

Parents are encouraged to attend their child's appointments. For questions about services offered, call 815-490-1600.

Child's Name: _____, _____, _____ Child's Date of Birth: ____/____/____
(Last) (First) (MI)



Medical Doctor _____ Phone _____

Date of last Medical Visit _____ Last Dental Visit _____ Last Eye Exam _____

Taking any medications? **Y / N**

If YES, list drugs: a) _____ c) _____
b) _____ d) _____

Are you allergic to penicillin? **Y / N** Are you allergic to any other medications? **Y / N** _____

Are you allergic to latex? **Y / N**

FEMALES: Are you pregnant? **Y / N** If yes, how many months? _____ Taking Birth Control Pills **Y / N**

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Kidney Problems	<input type="checkbox"/> Cigarette smoker/smokeless	<input type="checkbox"/> Blindness
<input type="checkbox"/> Bleeding/Blood clotting	<input type="checkbox"/> Asthma/wheezing/bronchitis	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Diabetes <input type="checkbox"/> Insulin	<input type="checkbox"/> Cancer/Leukemia	<input type="checkbox"/> Anxiety/Depression	<input type="checkbox"/> Crohns
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Panic Disorder	<input type="checkbox"/> Lupus
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Colitis
<input type="checkbox"/> Seizures (Convulsions)	<input type="checkbox"/> Drug/Alcohol dependency	<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Received steroid treatment	<input type="checkbox"/> Skin conditions	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Macular Degeneration

Does your child have a history of, or is currently suffering from a medical condition not mentioned above? **Y / N**

If YES, what is the medical condition? _____

Has your child's medical doctor recommended any special precautions for dental treatment? **Y / N**

Does your child have: Blindness **Y / N** Hearing Problems **Y / N** Speech Problems **Y / N**

Do you want your child to receive a flu shot? **Y / N**

I certify that I have read and understood the above questions. To the best of my knowledge the above information is correct.

I will not hold Crusader Community Health, the treating doctor/dentist or any member of the staff responsible for any errors or omissions I may have made in the completion of this form. I understand that it is my responsibility to inform my child's medical and dental provider when there is a change in my child's medical condition, or when there is a change in the responses to any of the above questions.

PERSON COMPLETING THIS FORM: _____ **SIGNATURE:** _____

RELATIONSHIP TO PATIENT: _____ **DATE:** _____ **TIME:** _____

Are you legally responsible for this child? Y / N



PATIENT INFORMATION

FULL NAME: _____ DOB: _____ MALE/FEMALE _____
 SCHOOL: _____ GRADE: _____

PARENT/GUARDIAN CONTACT INFORMATION

NAME: _____ DOB: _____ RELATIONSHIP: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 HOME PHONE: _____ CELL PHONE: _____
 WORK PHONE: _____ CAN WE CALL YOU AT WORK? Y / N _____
 EMAIL: _____
 BEST WAY TO CONTACT YOU? CHECK ALL THAT APPLY
 HOME _____ CELL _____ WORK _____ EMAIL _____

EMERGENCY CONTACT INFORMATION

NAME: _____
 RELATIONSHIP TO PATIENT: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 HOME PHONE: _____ CELL PHONE: _____

BACKGROUND INFORMATION

PRIMARY LANGUAGE:
 ENGLISH _____ SPANISH _____ OTHER _____
 ETHNICITY:
 HISPANIC OR LATINO _____ NON HISPANIC OR LATINO _____
 RACE: WHICH CATEGORY BEST DESCRIBES YOUR RACE?
 _____ AMERICAN INDIAN OR ALASKA NATIVE _____ ASIAN _____ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER _____ WHITE
 _____ BLACK OR AFRICAN AMERICAN _____ HISPANIC _____ OTHER RACE _____

INSURANCE INFORMATION

DO YOU HAVE MEDICAID/ALLKIDS? Y / N _____
 RECIPIENT ID# _____
 DO YOU HAVE PRIVATE HEALTH INSURANCE? Y / N _____
 NAME OF INSURANCE COMPANY _____ MEDICAL / DENTAL / OPTICAL
 NAME OF POLICY HOLDER _____ DOB (POLICY HOLDER) _____
 POLICY OR ID# _____ GROUP# _____
 NAME OF INSURANCE COMPANY _____ MEDICAL / DENTAL / OPTICAL
 NAME OF POLICY HOLDER _____ DOB (POLICY HOLDER) _____
 POLICY OR ID# _____ GROUP# _____

IF YOUR CHILD DOES NOT QUALIFY FOR MEDICAID/ALLKIDS (i.e. OLDER THAN 18) WE MAY HAVE OTHER OPTIONS AVAILABLE. PLEASE CONTACT US AT 815-490-1600 FOR MORE INFORMATION. SERVICES CAN ALSO BE PAID FOR IN CASH, CHECK OR CREDIT CARD.

THE HEALTH CENTER IS COMMITTED TO SERVING YOUR CHILD WITHOUT CAUSING FINANCIAL DIFFICULTIES