

Dear Parent/Guardian,

You must complete the attached consent form for your child to use the Crusader Community Health School-Based Health Center at Auburn High School.

Instead of signing your child up for services, **you must cross out services on Page 3 that you do not want your child to receive.** Please draw a line through any unwanted services on Page 3 of this consent form, and write your initials next to that service.

If you do not want your child to receive any services, you must draw a line through all services and sign your initials next to each service.

All three parts of the consent form must be completed and signed.

If you have questions or concerns about services for your child, please contact Crusader Community Health at 815-460-1600. If you have questions about the school transport program, please contact RPS 205 Health Services at 815-490-4105.

Thank you!

Health Services
Rockford Public Schools



(815)490-1600



(815)490-1600



(815)209-9642

Crusader Community Health - Auburn Campus

A School-Based Health Center

Crusader Community Health – Auburn Campus, a School-Based Health Center, consists of a seamless partnership of trusted local agencies dedicated to the health and well-being of your child. The partnership includes a nurse practitioner, physician assistant, dentist, dental hygienist, optometrist, behavioral health provider, and their assistants, available based on schedules, to provide medical, dental, optical, and/or mental health services at the health center. Please complete and sign the attached consent forms and return them to the health center or to your child’s school nurse.

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 through Friday, weather permitting, except for New Year’s Day, Memorial Day, Fourth of July, Labor Day, Thanksgiving, and Christmas. A parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf to receipt of health care services has a right to refuse any health care services.

Crusader Community Health and its associates will bill to private insurance and Medicaid (All Kids). It is recommended that you check with your insurance carrier to ensure coverage for specific services. **No child will be denied services due to the inability to pay.**

- Parental Consent for Treatment: Allows us to perform the services your child needs.
- Medical History and Insurance Information form: Lists details and information the doctor or dentist may need to know about your child and information to bill for services.
- Consent to Release Information and to Transport: This allows providers and the district to share information and to transport your child to the health center for approved services.

After you sign and return these forms, your child will be able to obtain services provided at the health center which may 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 ➢ Blood draw 	<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 ▪ Wellness promotion (including, but not limited to: smoking cessation and weight management)
	Dental Services	Optometric
	<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.



Student Name _____ Date of Birth _____ Student ID# _____

Services are provided by Crusader Community Health, Rosecrance and Rockford Family Eye Care. District No. 205 will transport eligible students to and from District No. 205 schools and the school based health center. The following services are available at the school-based health center based on your signed consent.

If you do not wish for your child to receive any of the services below, please draw a line through and initial next to that service.

I hereby authorize the Service Organization and clinic staff to administer

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 ➢ Blood draw 	<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 ▪ Wellness promotion (including, but not limited to: smoking cessation and weight management)
	Dental Services	Optometric
	<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

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 would like the health providers to contact me before scheduling my student for services at the health center.

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 consent to the release of relevant health information and medical records in connection with treatments to the school-based health center and its collaborating partners to facilitate my child's health needs. I further authorize the school-based health center to release information regarding my child's treatment to third party payors or others for billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality.
- 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.
- I understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.
- I understand that if my child is 12 or older they can receive mental health and substance abuse services at the health center without my consent. Per 405 ILCS 5/3-5A-105(a), they may receive up to eight 90-minute sessions for mental health services.
- I authorize the Service Organizations to communicate with my child's regular primary care provider and/or dentist.

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.

Other Assignments and Authorizations

- I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from such medical/dental treatment.
- 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 receive services as 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.

Patient Information

Name: _____ DOB: _____ Gender: _____
 School: _____ Grade: _____ Student ID: _____
 Social Security #: _____

Parent/Guardian Contact Information


Name: _____ DOB: _____ Relationship to Patient: _____
 Address: _____
 City: _____ State: _____ ZIP: _____
 Home Phone: _____ Cell Phone: _____ Text OK? Y / N
 Work Phone: _____ Can we call you at work? Y / N
 Email: _____
 Best way to contact you? (check all that apply) Home _____ Cell _____ Text _____ Work _____ E-mail _____

Emergency Contact Information

Name: _____ Relationship to patient: _____
 Address: _____ 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 _____

 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, and that each organization can only be held liable for the services they perform.

Signature of Parent/Guardian: _____ Date: _____

*Physicals are required for all students entering pre- school, kindergarten, 6th, and 9th grade before the first day of school. Documentation of basic immunizations is required with all school physicals. Oral health exams are required for all children in kindergarten, 2nd, and 6th grade prior to May 15th of the school year. All children enrolling in Kindergarten and any student enrolling for the first time in a public, private, or parochial school are required to have an eye exam before the first day of school.



Medical History and Insurance Information



Student's Name _____ Birthdate: _____ Student ID: _____

Medical Doctor _____ Address _____ Phone _____

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

Are you currently under the care of a medical doctor? ___Yes ___No Reason: _____

Taking any medications? ___Yes ___No If Yes, list drugs:

a) _____ Reason: _____ c) _____ Reason: _____

b) _____ Reason: _____ d) _____ Reason: _____

Are you allergic to... latex? ___Yes ___No penicillin? ___Yes ___No any other medications? ___Yes ___No please list: _____

Females: Are you pregnant? ___Yes ___No if yes, how many months? _____ taking birth control pills ___Yes ___No

Does your child have any of the following medical conditions: Yes No Comments

Table with 4 columns: Condition, Yes, No, Comments. Rows include ADD/ADHD, Anxiety or depression, Asthma or wheezing, Bleeding or blood clotting problems/diseases, Birth defects, or genetic defects, Cancer, leukemia, other tumor, Cigarette or smokeless tobacco use, Convulsions/Seizures or fainting spells, Developmental delays, Diabetes (Blood sugar problems), Drug and/or alcohol dependency, Headaches/migraines, Hearing problems, Heart disease, heart murmur, or heart surgery, Hepatitis or other liver problems, HIV and/or AIDS, Kidney problems, Mental retardation or delay in normal development, Received steroid treatment, Sickle cell anemia or trait, Thyroid problems, Tuberculosis, Others not listed.

Please check any optical conditions your child has:

Table with 4 columns: () Blindness, () Glaucoma, () Ocular Surgery, () Macular Degeneration, () Cataracts, () Other.

Other conditions not listed: _____

Insurance Information

Do you have Medicaid/All Kids? Y / N Recipient ID# _____
Do you have private health insurance? Y / N Name of Insurance Company _____
Type of Insurance: MEDICAL / DENTAL / OPTICAL Policy or ID# _____ Group # _____
Name of Policy Holder _____ DOB (Policy Holder) _____

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: _____

Contact Phone Number: _____ Are you legally responsible for this child? ___Yes ___No

Intentionally left blank.

Consent to Share Information and to Transport



Student's Name: _____ DOB: _____ Student ID#: _____

Acknowledgement of Release of Information

The Board of Education of Rockford Public School District No. 205 (District 205) has partnered with Crusader Community Health (Service Organization) to provide medical, dental, optical and mental health services to District 205 students.

By signing this consent, I authorize the Service Organizations, their individual service providers, their supervisors and District 205 to exchange and discuss appropriate information (student summary page, health history information, relevant patient information, etc.) to facilitate my child's treatment.

Consent to Transport

The Board of Education of the Rockford Public Schools, District No. 205 ("District No. 205") has arranged with Crusader Community Health ("Service Organizations") to provide health services for eligible District No. 205 students. I understand I am providing this Consent for the purpose of obtaining professional health services for my child listed at the top of this form and for the other purposes described in this Consent.

Appointments take place during the school day. A district chaperone and transportation to and from the clinic will be provided for students, if needed and if available. Parents are welcome, but *not required*, to attend. If my child needs transportation for appointments, I consent to having District 205 transport my child to and from the school-based health center for services, at no cost to me.

District No. 205 will transport eligible students to and from District No. 205 schools and the Service Organization's clinic.

- a) If my child needs transportation as indicated below, I consent to having one of the Service Organizations schedule District No. 205 transportation to take my child to and from District No. 205 for dental services, at no cost to me.
- b) I agree that District No. 205 may seek reimbursement from Medicaid for such transportation services.

If my child is seen at the end of the school day, my child:

- May walk home with their siblings (named) _____
- May walk home with a friend (s) (named) _____
- Should be transported to babysitter/child care provider named _____ located at _____ and can be reached at this number _____
- Should be transported home.

Questions about the transport program can be directed to RPS205 Health Services by calling (815)490-4105.

Questions about the services offered can be directed to Crusader Community Health by calling (815)490-1600.



Person completing this form: _____ Signature: _____

Relationship to patient: _____ Date: _____

Contact Phone Number: _____ Are you legally responsible for this child? ___ Yes ___ No

Intentionally left blank.