CRUSADER COMMUNITY Health

Care Within Reach

SOUTH BELOIT Community Unit School District 320

South Beloit School District 320

(815)490-1600
Crusader Community Health – South Beloit

A School-Based Health Center

Crusader Community Health, in collaboration with South Beloit School District 320 is pleased to offer health services to students in the district. If you would like your child to receive medical, dental, 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 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.

Crusader Community Health 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.**

- Consent to Release form: Allows us to share appropriate information with District 320 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:

<table>
<tr><th>Medical Services</th><th>Behavioral Health Services</th><th>Health Education</th></tr>
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<td rowspan="2">

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

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:

abstinence counseling
diagnosis/treatment of sexually transmitted infections
pregnancy testing
contraceptive counseling/exams/prescription

Basic lab tests

Strep test
Blood draw

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Crisis intervention and linkage to appropriate crisis intervention services if needed
Behavioral Health services including:

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

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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

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<tr><th>Dental Services</th><td></td></tr>
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Exams/cleanings
Restorative (fillings, stainless steel crowns)
Extractions
Emergency care for pain

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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.

South Beloit School District 320

Student Name_____ Date of Birth_____ Student ID#_____

The following services are available at the School-Based Health Center based on your signed consent. Please check the box to indicate which services you would like your student to receive this school year.

Appointments take place during the school day. A district chaperone and transportation to and from the clinic will be provided for students, if needed. Parents are welcome, but *not required,* to attend.

☐ 1. Physical exam/sports physical/immunizations required by state law (blood draw may be a part of these exams).

2. Immunizations strongly recommended by the American Academy of Pediatrics:
   ☐ HPV (Age 11 and up) ☐ Hepatitis A ☐ FLU ☐ None

☐ 3. Dental Exam

☐ 4. Nutritionist

Do you currently have a Medical Provider/Doctor? Name _____

X_____ X_____

Parent/Guardian signature **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.

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

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

Crusader Community Health (Service Organization) has partnered with South Beloit School District No. 320 to provide medical, dental, and mental health services to District 320 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. 320 to exchange and discuss appropriate information to facilitate 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-South Beloit, 840 Blackhawk and 245 Prairie Hill Rd, South Beloit, IL 61080.

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.

Authorization for Treatment/Transportation

Services are provided by Crusader Community Health, and Rosecrance. District No. 320 will transport eligible students to and from District No. 320 schools and the School Based Health Center.

- If my child needs transportation as indicated below, I consent to having District No. 320 transport my child to and from the School Based Health Center for services, at no cost to me.
- 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 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.

Signature of Parent/Guardian:_____ Date: _____

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: _____

b) _____ Reason: _____

c) _____ Reason: _____

d) _____ Reason: _____

Are you allergic to...latex? ___Yes ___No penicillin? ___Yes __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**
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:

( ) Blindness	( ) Glaucoma	( ) Ocular Surgery	( ) Macular Degeneration
( ) Cataracts	( ) Other		

Other conditions not listed: _____

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**

CRUSADER COMMUNITY Health

PATIENT INFORMATION

NAME:_____ DOB:_____ MALE / FEMALE

SCHOOL:_____ GRADE:_____STUDENT ID:_____

SOCIAL SECURITY #:_____

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 _____

INSURANCE INFORMATION

DO YOU HAVE MEDICAID/ALL KIDS? 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#_____

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_____

CRUSADER COMMUNITY Health

PATIENT'S DENTAL HISTORY

1. Reason you are seeking dental care for patient: _____
2. Has patient ever been to a dentist before? ____Yes ____No If yes, name of dentist_____
3. Has patient ever had any of the following?

	Yes	No	Comments
Injuries to the mouth or teeth?			
Toothache and/or abscesses?			

4. Does patient have any of the following habits?

	Yes	No	Comments
Finger, thumb or pacifier sucking?			
Mouth breathing?			

5. Is your child taking fluoride supplements in any form? ___Yes ___No
6. Do you think patient receives proper daily dental care? ___Yes ___No
7. What type of water does patient drink? ___Community tap water ___Well water ___Bottled water
8. Other dental information we should know? _____

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 the treating dentist(s) or any member of the dental 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 patient's dentist when there is a change in my patient'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: _____

Phone number where you can be reached during the day: _____

Are you legally responsible for this patient? _____

(If NO, we may need a written or oral consent from the person/institution legally responsible for this child.)

CRUSADER COMMUNITY Health

Student: _____ ID#: _____ School: _____

Birthdate: _____ Gender: _____ Grade: _____ Room: _____

Consent and Registration Form

This form is to obtain your consent for dental treatment or oral surgery procedures. Please read this form very carefully and ask us about anything that you do not understand. Your child's dentist or the dental staff will be pleased to explain it. Thank you.

Patient Name: _____ Guardian Name: _____

Address: _____ [ ] CHECK IF SAME Address: _____

_____ _____

City: _____, IL ZIP: _____ City_____, IL ZIP_____

Email_____

Phone number(s) where you can be reached during the day:

Cell _____ Home _____ Work _____

Medicaid: 9 or 11-Digit Medicaid Recipient ID Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

If you are insured through a private insurance carrier please complete this section:

Private Dental Insurance Company: _____ Group Number: _____

Company Phone Number: _____ Policy Number: _____

Address to send claims (on card): _____

Name of person under whom patient is covered: _____ Employer: _____

Birth Date of Insured Adult: _____ Social Security Number: _____ Employer Phone: _____

(If possible attach photocopy of front and back of card)

I hereby authorize payment of dental benefits for the services described. I give my permission to the doctor to submit insurance benefit claim forms in my name and on the behalf of myself, my spouse and/ or my minor patient. I realize that I may be responsible for and agree to pay any charges not covered by my insurance. This includes unmet deductibles, non-covered services, etc.*

*Patients covered through Medicaid will not have a copay for covered procedures.

A. Below is a list of dental procedures that may be performed on your patient. A treatment plan will be made for your child and sent home after their initial appointment. Since you may not be present at dental appointments, it is important that you read this material carefully and call the appropriate provider if you have any questions.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. **Local Anesthesia Injection:** "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. **Dental Rubber Dam:** A sheet of rubber used to carefully isolate the teeth that need dental treatment.
7. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
8. **Pulp (tooth nerve) Treatment/ Root Canal:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the patient with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them. It is important to complete a final restoration/crown after a root canal on a permanent tooth to prevent reinfection of the tooth.
9. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth crowding), or if they are diseased and cannot be saved by any dental procedures.

Do you wish to be contacted before extractions? ___yes ___no

If we are unable to contact you and [yes] is circled we will not proceed with treatment that day.

11. **Space Maintainer:** Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.
12. **Other:** _____

Continued on back >>>

B. The following are the behavior management techniques that may be used on children who do not cooperate in the dental chair. Please note that these techniques are used carefully, and only when necessary.

1. **Voice Control:** Voice control is a controlled alteration of the voice volume, tone or pace to influence and direct the patient's behavior. The attention of an uncooperative or inattentive child is gained by using a firm tone, changing the tone or increasing the volume of the voice.
2. **Physical Restraint by the Dentist:** The dentist gently restrains the child from unwanted and unexpected movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body or positioning the child firmly in the dental chair.
3. **Physical Restraint by a Dental Assistant(s):** The assistant(s) gently restrain the child from unwanted and unexpected movement by holding the child's hands, stabilizing the head and/or controlling let movements.
4. **Mouth Prop:** A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses to open the mouth or has difficulty maintaining an open mouth.
5. **Papoose Board:** Used only in special cases. This is best described as a "safety robe" or "blanket" allowing the child to feel secure rather than threatened. The papoose board allows the needed dental work to be done while minimizing the possibility of accidental injury to the child due to uncontrolled body movements.

C. The nature and purpose of the treatment and procedures has been explained to me in general terms. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

D. I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

E. **Risks and Complications:** Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The more common complications associated with dental treatment include nausea following the administration of topical fluoride or local anesthesia and patient biting and injuring their tongue or lip following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, such as an extracted tooth or gauze packing, injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. For patients with certain heart diseases, the risk of **Infective Endocarditis** (heart infection) following certain dental procedures exists. In such cases, the dentist may prescribe antibiotics before treatment begins, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

F. I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my patient's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections? _____Yes or _____ No

If yes, please explain _____

G. By signing this consent form, I authorize and direct the dentists of Crusader Community Health assisted by the dental staff of his/her choice, to perform upon my patient (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained.

I also hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

H. I understand that each dental provider can only guarantee the work that they do. Therefore, I will not hold a provider liable for dental work completed by a different provider.

If our office begins treatment for this child and cannot complete the care within the time allowed, it is your responsibility to make other arrangements for the care of this child.

Today's date: _____

Patients Name: _____ Date of Birth: _____ Student ID: _____

Name of person completing form: _____ Signature: _____

Your relationship to patient: _____ Daytime Phone: _____

Are you legally responsible for this patient? _____Yes_____No
(If no, we may need a written or oral consent from the person/institution legally responsible for this child.)

Crusader Community Health Dental Department: 815 490-1374/ 815 490-1428