Bullock County School-Based Clinic

Dear Parents and Guardians:

Enclosed are the enrollment and consent forms for the Bullock County School-Based Clinic for the 2026-2027 school year.

What Is the School-Based Clinic?
The Bullock County School-Based Clinic is an extension of the Auburn University College of Nursing (AUCON). The clinic is staffed by nurse practitioners who collaborate with providers at AUCON, Perfect Kids and Family Care (PKFC) to support the health and well-being of Bullock County students.

Why Is It Important?
The clinic provides convenient access to healthcare services while students are at school, helping students stay healthy and ready to learn. Services include annual wellness exams and checkups, sports physicals, health screenings and education, care for illness and injury, and behavioral health services including emotional support, conflict resolution, anger management, and social skills education. Most services are supported by health insurance.

Who Is It For?
The clinic is available to students enrolled in Bullock County Schools whose parents or guardians have completed the required enrollment and consent forms.

ACTION REQUIRED: Please return all completed forms in this SEALED ENVELOPE to the FRONT OFFICE. *(Enrollment and consent forms must be completed and signed each school year before your child can receive services through the clinic.)*

How Is My Child's Information Protected?
Your information and your child's information will not be shared with the school. Information provided on the enrollment forms will be entered into our secure electronic health record system.

We look forward to partnering with you and your family to support your child's health and success throughout the school year.

- From your Auburn College of Nursing Bullock County School-Based Clinic Team

Auburn University College of Nursing/ Perfect Kids & Family Care

Bullock County Schools

SCHOOL-BASED CLINIC ENROLLMENT FORM

The school-based clinic at **Bullock County Schools** offers complete physical exams in person or via telehealth and will see your child if they are sick or need behavioral health services.

I,_____ (**guardian's name**), grant permission for _____ (**child's name**) _____-__-__ (**child's date of birth**) to enroll as a participant in the BULLOCK COUNTY SCHOOL-BASED CLINIC during the 2026-2027 school year, as indicated below.

I can withdraw my _____(child's name) from participation in the school-based clinic at any time by notifying the school-based clinic staff. Withdrawal will not affect the care my child received prior to withdrawal nor the related financial responsibility.

I will notify the school-based clinic staff if guardianship or custody of _____ (child's name) changes during the school year, so that the school-based clinic staff can obtain updated enrollment and consent forms for my child.

Please check the box beside the services you are enrolling your child to receive:

☐ COMPLETE PHYSICAL EXAMINATION (including EPSDT* ex: Medicaid screenings, health/puberty teaching, and limited diagnostic testing).

**EPSDT - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid.*

☐ SICK VISITS (headache, sore throat, stomachache, etc.).

☐ BEHAVIORAL HEALTH SERVICES

Signature of Guardian: _____

Printed name of Guardian: _____

Date:_____

Auburn University College of Nursing/ Perfect Kids & Family Care
Bullock County Schools
PATIENT INFORMATION

Student's Name: _____

Student Date of Birth:_____ Gender: Male_____ Female _____

Student Social Security Number: _____

Guardian Name (Print Please): _____

Guardian Date of Birth: _____

Guardian Social Security Number: _____

Guardian's relationship to child: _____

Guardian's Home Address: _____

City:_____ZIP: _____

Guardian's place of employment: _____

1. Child's Medicaid number: _____
2. Child's CHIP number: _____
3. For private insurance, please complete the following:

   Name of policyholder: _____

   Relationship to child: _____

   Name of insurance company: _____

   Group #_____Policy # _____

Guardian phone numbers:1._____(home or cell)

2._____(Work)

If we are unable to reach you, who else may we contact regarding your child?

Name:_____Relationship:_____Phone #: _____

Name:_____Relationship:_____Phone #: _____

Name:_____Relationship:_____Phone #: _____

Preferred Pharmacy and Address: _____

_____

Signature of Guardian: _____

Printed name of Guardian: _____

Date: _____

Auburn University College of Nursing/ Perfect Kids & Family Care
Bullock County Schools

MEDICAL INFORMATION

MEDICAL HISTORY: (TO BE COMPLETED BY GUARDIAN)

Student's Name:_____ Date of Birth: _____

List your child's allergies, if any (food, medications, etc.): _____

List your child's daily medications (name of medicine, amount, when taken, etc.): _____

(Please include any inhalers or nebulizers-include average number of times per week that patient needs rescue medications)
Date of child's last dental exam: _____

PLEASE CIRCLE "YES" OR "NO" FOR EACH OF THE FOLLOWING:

Does your child have a medical history of:

ADD/ADHD	YES	NO
Behavioral Problems	YES	NO
Allergies	YES	NO
Asthma	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Eczema	YES	NO
Headaches/migraines (frequently)	YES	NO
Hearing Loss	YES	NO
Heart murmur/disease	YES	NO
HIV/AIDS	YES	NO
Inflammatory bowel disease	YES	NO
Jaundice	YES	NO
Lead poisoning	YES	NO
Meningitis	YES	NO
Obesity	YES	NO
Otitis media/ Ear problems	YES	NO
Pneumonia	YES	NO
Scoliosis	YES	NO
Seizures	YES	NO
Sickle Cell	YES	NO
Strep throat (recurring)	YES	NO
Trauma	YES	NO
UTI (Urinary Tract Infection)/ Kidney problems	YES	NO
Varicella	YES	NO
Vision problems/Wears glasses	YES	NO
Stomach problems/Frequent stomachaches	YES	NO
Problems as a newborn or premature delivery	YES	NO
Permanent physical disability	YES	NO

If you answered "YES" to any of the above, please explain: _____

_____

Signature of Guardian:_____ Date: _____

PLEASE CIRCLE "YES" OR "NO" FOR EACH OF THE FOLLOWING:

Does your child have a surgical history of:

Adenoidectomy	YES	NO
Appendectomy	YES	NO
Cleft lip	YES	NO
Cleft palate	YES	NO
Ear tubes	YES	NO
Gastrostomy	YES	NO
Heart Surgery	YES	NO
Inguinal hernia	YES	NO
Lymph node biopsy	YES	NO
Tonsillectomy	YES	NO
Umbilical hernia	YES	NO
VP Shunt	YES	NO

If you answered "YES" to any of the above, please explain: _____

_____

Family History of any of the following **before the age of 55**: Please circle below.

- □ Heart diseases / high cholesterol----mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ High blood pressure ----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Diabetes ---------- mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Sudden death from heart problems--mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Kidney disease ---------- mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Asthma / Lung disease ----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle

In your family, has anyone ever been diagnosed and/or treated for the following:

- □ Schizophrenia----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Depression ---------- mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Anxiety ----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Alcoholism----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle
- □ Drug abuse ----------mom / dad / grandma / grandpa / sister / brother / aunt / uncle

*****Please notify the clinic if your child's health status changes in any way after turning in this health history*****

Signature of Guardian: _____ Date: _____

Printed name of Guardian: _____

AUBURN UNIVERSITY
College of Nursing

BULLOCK COUNTY
Rural Emergency Hospital
and Bullock County Schools

BULLOCK COUNTY SCHOOLS

SCHOOL-BASED CLINIC

Consent for Treatment, Authorization to Release Medical Information, Assignment of Insurance Benefits for In-Network Health Care Providers

CONSENT FOR TREATMENT: The undersigned authorizes Perfect Kids and Family Care (PKFC), the Auburn University College of Nursing (AUCON) and its employees or any contractor on behalf of PKFC and AUCON to furnish medical treatment deemed appropriate including antibiotics or other drugs deemed necessary during the episode(s) of care occurring during the 2026-2027 school year for which I have enrolled my child as a participant in the school-based clinic identified above. I can withdraw my consent prior to or during any episode of care by notifying my PKFC or AUCON care provider. My withdrawal of consent will not affect the care I received prior to withdrawal nor the related financial responsibility. I am aware that adverse unforeseen reactions can occur and may even result in death. I authorize PKFC and AUCON to take photographs, video, audio, or other images or recordings of me or parts of my body while under the care of PKFC and AUCON for use in medical evaluation, performance improvement, education or scientific research. I further understand that my identity will be concealed and my privacy maintained if the material is used for educational purposes.

I hereby authorize PKFC and AUCON: to preserve, use or disclose, or share for scientific or teaching purposes, including research; to use in grafts or transplants upon living person(s); or to otherwise dispose of dismembered tissue, blood, saliva, parts and the like.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize PKFC and AUCON to release or disclose information from my medical record pertaining to the episode(s) of care occurring on the date signed below, in accordance with the policies of PKFC and AUCON, to insurance companies and/or hospital benefits programs as needed to process resulting claims.

IN-NETWORK AUTHORIZATION TO PAY INSURANCE BENEFITS: If PKFC is in-network with my insurance provider, I hereby assign payment directly to PKFC, benefits payable to me but not to exceed PKFC's regular charges for the episode(s) of care occurring on the date signed below. I understand I am financially responsible for all charges that may result from services provided to me which are not covered or paid by my insurance provider, including but not limited to all deductible, co-payment, and co-insurance amounts.

OUT OF NETWORK INSURANCE BENEFITS: If PKFC is not in-network with my insurance provider, I acknowledge that PKFC is not accepting assignment of benefits or written direction of payments from my insurance provider, unless such payments are for emergency or air ambulance items and services. Further, I acknowledge and agree that I do not seek to have a claim for items or services provided at PKFC or by a PKFC or AUCON healthcare provider submitted to my insurance provider, unless such claims are for emergency or air ambulance items and services. I understand

that I will be financially responsible for all charges that may result from services provided to me.

FINANCIAL AGREEMENT: For services rendered, I, the undersigned, agree to pay PKFC all charges not covered by insurance or charges covered by my insurance plan for items or services provided by PKFC out-of-network, as described above. I also agree to pay all attorney and/or collection fees necessary for the collection of payment by PKFC.

MEDICAID PATIENT CERTIFICATION [applicable only to those enrolled in Medicaid]: I certify that I am a recipient of the Medicaid Title XIX Program and request the payment of authorized benefits be made on my behalf. I authorize any holder of medical or other information about me to make available to the Division of Medicaid any requested information concerning medical, insurance and financial records related to my healthcare. I assign the Medicaid benefits payable for services rendered to the physicians or organization furnishing such services.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER PHYSICIAN AND PATIENT [applicable only to those enrolled in Medicare]: I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services rendered to the physicians or organization furnishing such services.

NOTICE TO BENEFICIARIES OF COINSURANCE LIABILITY: When services are provided in hospital departments, the beneficiary will receive a hospital bill and will receive bill(s) from any physician providing professional services. The beneficiary/guarantor will be responsible for coinsurance amounts relating to services billed by the hospital and for coinsurance amounts relating to services billed separately by the physician(s). When services are provided in private physician offices or other non-hospital clinics, the beneficiary is responsible only for coinsurance amounts relating to charges billed by the physician.

CELL PHONE/PAGER AUTHORIZATION: I agree that PKFC, and all of its related entities, agents, servicers, debt collectors, independent contractors, assigns, and successors may call, message, text, or otherwise contact me (hereinafter "communication"), including through the use of dialing equipment (including a dialer, automatic telephone dialing system, and/or interactive voice recognition system) and/or artificial or prerecorded voice message, even if I am charged by my telecommunication provider or other party of the communication. I expressly agree that such communication may be made by PKFC to any telephone number (including numbers assigned to any paging, cellular, or mobile service, or any service for which I am charged for the communication) I have provided previously or may provide in the future in connection with my account. I expressly consent to receiving any such communication. With such consent, I specifically waive any claim I may have against the PKFC for making such communications to me, including any claim under federal or state law and specifically any claim under the Telephone Consumer Protection Act, 47 U.S.C § 227.

RETIREMENT/DESTRUCTION OF X-RAYS: I hereby authorize PKFC to retire x-ray films and any other graphic data which may be generated during patient's hospitalization or otherwise four **(4)** years after they are generated if a report of the findings is retained for the same period as other medical records. Further, I hereby release and hold harmless PKFC, its officers, staff and employees, from any liability connected with this procedure.

Signature of Patient, Guardian, or Representative	Signature of Insured
Date/Time	Date/Time
Description of Representative	

Medical Record Number

Perfect Kids & Family Care
Acknowledgement of Receipt of Notice of Privacy Practices

Effective Date: January 1, 2020

I agree that I have received a copy of the PKFC Notice of Privacy Practices.

Print patient's name_____ Date _____

Signature of patient or representative _____

Description of personal representative's authority _____

PKFC Use Only

The following should be completed only if the patient cannot sign or refuses to sign the acknowledgement

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but was unable to obtain acknowledgement because:

_____

Employee signature_____ ID number_____

Date _____

PERFECT KIDS & FAMILY CARE NOTICE OF PRIVACY PRACTICES

Revised Effective Date: September 11, 2025

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY.

PKFC creates a record of the care and services you receive from us. We call this record your health information. We are required by federal law to keep your health information private. We are also required to provide you with this Notice so that you will know how we use and disclose your health information and how you can get access to this information. This Notice also lists the rights you have regarding your health information. We will abide by the terms of the Notice. This Notice covers your care provided at all PKFC sites of service. We reserve the right to change the terms of this Notice and our privacy practices at any time. Any changes will apply to the health information we already have. When we make changes to our privacy practices, we will post an updated Notice in the places where you may receive treatment from PKFC. You can also request a copy of this Notice at any time, and you may view a copy of the Notice on our web site at www.bullockcountyhospital.com.

Uses and Disclosures That Do Not Require Your Signed Permission

- **Treatment.** We may use or disclose your health information to doctors, nurses, technicians, medical students, students in other health care fields, or other personnel who are involved in taking care of you. For example, a doctor treating you for chest pain may need to know if you have any existing heart problems so that he/she can make an informed decision concerning your treatment. Additionally, we will/may contact you to (1) remind you of your appointment by calling, e-mailing, texting, or mailing a postcard, or through the patient portal; or (2) discuss treatment alternatives or other health related benefits that may be of interest to you as a patient.
- **Payment.** We may use or disclose your health information in order to bill and receive payment for services you receive. For example, we will disclose some of your health information to your health insurance company in order to receive payment for your treatment.
- **Health Care Operations.** We may use and disclose your health information to conduct activities that are called health care operations. For example, PKFC personnel or others that perform services for PKFC may review your health information to assure the quality and appropriateness of the care you receive.
- **Fundraising Activities.** We may contact you about PKFC fundraising activities. You will have the opportunity to opt out of any fundraising material and directions on how to do so will be included in that material. Opting out of fundraising will in no way, affect the care you receive from PKFC.
- **Health Information Exchanges.** We may make your health information available electronically to other health care providers or other health care entities for treatment, health care operations, or payment purposes by a state, regional, or national information exchange service. In doing this, we may receive information that they maintain about you so that you may have continuity in health care, treatment, or payments for health care services. We have implemented technologies that allow PKFC and community providers to create, maintain, and share a common electronic health record of their patients for the purpose of coordinating the care of these patients.
- **Emergencies**. We may use or disclose your health information in an emergency treatment situation.
- **Food and Drug Administration**. We may use and disclose your health information to a person or company required by the Food and Drug Administration to track adverse events and as otherwise required.
- **Worker's Compensation**. We may use and disclose your health information as necessary to comply with worker's compensation laws and other similar legally-established programs.
- **Federal, State or Local Law**. We may use and disclose your health information when required by law.
- **Government Agencies and Law Enforcement**. We may use or share your health information to government agencies for law enforcement purposes or with a law enforcement official.
- **Order by a Court**, Tribunal or Other Judicial Proceeding. We may disclose your health information when ordered by a court, tribunal or other judicial proceeding, or in response to a subpoena.
- **Public Health Reasons**. We may use or disclose your health information for public health reasons. For example, we can share health information about you for certain situations such as: preventing disease; helping with product recalls; reporting adverse reactions to medications; reporting suspected abuse, neglect, or domestic violence; or preventing or reducing a serious threat to yours or anyone's health or safety, such as instances of child and/or elderly abuse or neglect.
- **Coroners, Medical Examiners and Funeral Home Directors.** We may disclose your health information to a coroner, medical examiner or funeral home director.
- **Health Oversight Reasons.** We may disclose your health information to the government to be used to oversee the health care system.
- **Organ and Tissue Donation.** We may use and disclose your health information for organ and tissue donation.
- **Research**. We perform research here. Our researchers may look at your health records to prepare or perform research. They may also share your health information with other researchers. All patient research conducted at AUCON and PKFC goes through a special process required by law that reviews protections for patients involved in research, including privacy. We will not use your health information or disclose it for research reasons without either getting your prior approval or determining that your privacy is protected.
- **Disaster Relief Reasons.** We may disclose your health information for the reason of coordinating disaster relief efforts.
- **Specialized Government Functions.** We may disclose the health information of military personnel and veterans in certain situations to the government. We may also disclose your health information for national security reasons.
- **Inmates.** We may disclose your health information if you are an inmate of a correctional facility or under the custody of law enforcement.
- **Health Fairs/Screenings.** We may use your information to contact you with the results of any screenings that are not available on the day of the health fair/screening. We may keep a copy of your screenings to verify that you received screenings at a health fair.
- **Business Associates.** We may disclose your health information to outside companies or persons we have hired to carry out activities for or on behalf of AUCON and PKFC. We call these outside companies or persons business associates. For example, when you request a copy of your health information, we may use a copy service to make copies of your health information. To protect your health information, however, we require the business associate to appropriately safeguard your health information.
- **Treatment alternatives.** We may use and disclose your health information to manage and coordinate your health care and inform you of treatment alternatives and other health related benefits that may be of interest to you. This may include telling you about treatments, services, products and/or other health care providers. For example, if you are diagnosed with diabetes, we may tell you about nutritional and other counseling services that may be of interest to you.
- **Data Registries.** AUCON and PKFC participates in various data registries that further health care operations of AUCON and PKFC, its mission as an academic center and its research mission. Your information may be shared with one or more data registries. If your information is shared with a data registry for the purpose of health care operations, the registry is considered a business associate and your health information will be protected as described above under the topic "Business Associates". If your information is shared with a data registry for purposes of research, your information will be protected as described above under the topic "Research."

Uses and Disclosures to Which You Have the Opportunity to Object

- **People Who Help Take Care of You.** We may provide your health information to a family member, friend or other person, if he/she helps take care of you, or if he/she is responsible for paying for your care, unless you tell us not to. In emergencies, you will not be given the chance to tell us not to provide information to those who take care of you.
- **Hospital Directory**. If you are admitted to our hospital, your name, location within the hospital and religious affiliation will be listed in the hospital directory, unless you tell us not to list you. This information may be disclosed to persons who ask for you by name, such as family and friends, and to members of the clergy.

Other Uses and Disclosures Require Your Prior Written Permission

- **Psychotherapy Notes.** If we provide you with psychotherapy we will not disclose the notes made by the mental health provider during the therapy services, unless you and your provider give us written permission to disclose the notes.
- **Marketing.** Marketing information typically may only be used or disclosed by AUCON or PKFC if you provide AUCON or PKFC with written permission to use or disclose your information.
- **Sale of PHI.** Only in the event that we were to sell your health information.
- **Other Uses and Disclosures.** Other uses and disclosures will be made, of your health information, only with your written, signed permission. You may take back permission once you have given it and your refusal to provide permission will not be held against you; however, it may prevent us from completing a task you have requested, such an enrollment in a research study or to create a report for your attorney. The request to take back the permission must be made to AUCON or PKFC in writing. You can take back your permission but only if AUCON or PKFC has not already acted in reliance of your permission.

YOUR RIGHTS REGARDING OUR HEALTH INFORMATION

You have the right to inspect and to get copies of your health information. With only a few exceptions, you have the right to inspect, get hard copies of, and, with certain limitations, get electronic copies of your health information. You must make this request in writing. If we do not have your health information, but we know who does, we will tell you where to direct your request. In certain situations, we may deny your request. We will let you know if your request is accepted or denied within 30 to 60 days after receiving your written request. If we deny your request, we will let you know in writing why and explain your right to have the denial reviewed. If you request copies of your health information, we may charge you a fee based on our cost. We may provide you with a summary or explanation of the health information as long as you agree to accept a summary and the cost in advance.

You have the right to request a correction to your health information. If you believe that your health information is incorrect or information is missing, you may request that the information be changed or added. You must make the request in writing. You must also give us a reason for your request. Under certain circumstances, we may deny the request. We will let you know if we accept or deny your request within 60 days of receiving it. If we deny your request, we will let you know why in writing. We will also explain your right to file a written statement of disagreement. If we approve your request, we will make the change to your information. We will let you know when the change is made. We will also let concerned parties know when the change is made.

You have the right to request a listing of disclosures we have made of your health information. You have the right to request a listing of all disclosures we have made of your health information without your permission, except those disclosures made for purposes of treatment, payment, or health care operations, and those disclosures we made as required by law. We will respond within 60 days of receiving your request. Your request must state the time period desired for the accounting, which must be less than a six-year period prior to your request. The list will contain the date of the disclosure, the name of the recipient and address, if known, a description of the information disclosed and the reason for the disclosure. If you make more than one request in the same year, you will be charged a fee based on cost for each additional request.

You have the right to request restrictions on uses and disclosures of your health information. You have the right to request that we restrict the use and disclosure of your health information. We are not required to agree to your requested restrictions. How- ever, we will honor your request to not disclose your health information to your health plan if the disclosure is for payment or health care operations and is not otherwise required by law and the health information pertains solely to items or services for which you have paid out of pocket in full. You may request a restriction by submitting the appropriate AUCON or PKFC form.

You have the right to choose how we communicate with you. You have the right to request that we communicate with you in a certain way. For example, we encourage you to communicate via your MyChart account, but you may request that we communicate with you by U.S. mail. We require that you make your request in writing and we will agree to the request as long as we can easily meet it.

You have the right to receive notification in the event your health information is breached. In the event your unsecured protected health information is breached, we will notify you of the occurrence.

If you would like more information on accessing, obtaining a copy or obtaining a listing of the disclosures that we have made of your health information, you may contact PKFC's Release of information.

FILING A COMPLAINT: If you have any questions about this Notice, complaints about our privacy practices or would like information on how to file a complaint with PKFC or the Secretary of the Department of Health and Human Services, please contact: the PKFC Privacy Officer, at Bullock County Rural Emergency Hospital, 102 West Conecuh Avenue, Union Springs, AL 36089 or call the Information Line at 334-738-1417. You will not be penalized or retaliated against for filing a complaint.

NOTICE OF NONDISCRIMINATION: Patients have the right to: receive considerate, respectful delivery of care regardless of age, race, color, national origin, culture, ethnicity, language, socioeconomic status, religion, physical or mental disability, sex, sexual orientation, gender identity or expression, or manner of payment. If you believe AUCON or PKFC has discriminated on the basis of race, color, national origin, age, disability, sex, sexual orientation, gender identity or expression, you can file a grievance with PKFC's Privacy Officer.

ATTENTION: Language assistance services, free of charge, are available to you. If you need these services, please contact Language services at 601-984-2027.