HUMBOLDT PARK HEALTH
ADVANCING HEALTH EQUITY

Pediatric Mobile Services Consent

Any questions, please contact us at 773-292-2629

Child/Student Name: ______________________________ Date of Birth:___/___/___ Sex Assigned at birth: □M □F □Intersex
Current Gender: □Male □Female □Transgender-F(MTF) □Transgender-M (FTM) □Other: ______________________
School/Site Name: ____ Grade Level:__________________
Race/Ethnicity: □Black/African American □Caucasian/White □Hispanic/Latinx □Asian □Indigenous □Other: _____________
Phone Number: ( ) _____ - ______ □Home □Cell; Consent to: Text?: □Yes □No; E-mall?: □Yes □No
Email: ____ Email address belongs to: _________________________
Street Address: ____ City ___________State: ____Zip Code: ___________
Legal Guardian(s): ____ Relationship to Student: _______________________
Emergency Contact: □Same as above; □Other: ________________________________ Phone Number: ( ) ______-________
Insurance Type: _________________________________ Insurance#__________________________ □No Insurance

Student/Child's Health History:

□No □Yes Any allergies? Please list with reaction:____
□No □Yes Specific allergy to: Neomycin, Streptomycin, latex, gelatin, baker's yeast or eggs? (If yes, please circle)
□No □Yes Taking medications (including asthma pumps)? If yes, list name/dose/frequency:___________________________
□No □Yes Are there any immunizations that you do NOT want child/student to receive? If yes, list: _____________________
□No □Yes Has child/student ever had a reaction to a vaccine? If yes, please list: ____________________________________
□No □Yes Do you have any current health concerns about child/student? ____
□No □Yes Has child/student ever had surgery or been hospitalized (including pregnancy related care)?
If so, for what and when? ____
□No □Yes Has child/student seen a dentist within the last 6 months?
□No □Yes I would like to OPT OUT of dental services provided by the Mobile Services Team (which may include: basic dental exam, cleaning, fluoride varnish, and/or dental sealants). Opting out means student will not receive these no cost services).
□0 □1-4 □5-9 □>9 Estimated number of days per year child/student is absent from school related to medical/dental issues.

Current or past health problems: (Check boxes that apply to child/student. If no response, will assume child/student has none):
□NONE □Broken Bones □Sickle Cell Anemia □High Cholesterol □Bleeding Disorders □Leaming Disabilities
□Seizures □Heart Disease/Surgery □Born Premature □Growth Concerns □Anemia (low iron) □Asthma
□Diabetes □Fainting/Passing out □Concussion/Head Injury □ADHD/ADD □Depression □immunocompromised
□High Blood Pressure □Other ______________________

Access to Services:

Where does the child/student go to for medical services? □Clinic____________________________________□None □ER
Where does child/student go to for cavities/fillings/cleanings? □Clinic:___________________________ □School □None □ER
What is the biggest barrier for getting child/student to a medical or dental clinic?
CHOOSE ONE: □Transportation □Cost □Work schedule □Insurance □Clinic schedule □Child/student's schedule
Family Information:
□No □Yes Do the child's parents, grandparents, siblings. aunts or uncles have ... (If yes, circle & write who):
Diabetes High Blood Pressure Asthma Heart Disease High Cholesterol Growth Problem

Consent for Services:

I am legally able to consent to services for "Child/Student name" listed above. I have had the opportunity to read and fully understand the letter to guardians, the Notice of Privacy Practices, and this Consent Form. I understand risks associated with medical and dental services are low but do exist. **I give permission for Humboldt Park Health (HPH) to perform a physical exam, health screenings, laboratory testing, give all recommended and required immunizations (unless otherwise noted above) and dental services (unless noted above). Dental services may include: basic dental exam, cleaning, fluoride varnish, and/or dental sealants.** I understand that physicians and other health care professionals in training may, under appropriate supervision, participate in treatment, and I consent to their involvement. I give permission for the school/site to identify my child at time of service if my child cannot identify themselves. I acknowledge and agree that HPH may receive, use and disclose information concerning the child/student's care, prescription medications and health care coverage for treatment, payment and provision of health care operation. I acknowledge that HPH Mobile Services may visit my child's school more than once and give permission for my child/student to be seen at any time. I have received a link to the Vaccines Information Statement (https://www.cdc.gov/vaccines/hcp/vis/current-vis.html).I also give permission for information regarding these visit(s) or associated follow-up to be shared with my child/students' school/site for up to 1 year. I consent to participate in ICare (Illinois Comprehensive Automated Immunization Registry Exchange). Lastly, I give permission to contact me via phone, text or email (unless otherwise noted above) and will assume responsibility for any recommendations regarding follow-up needs.

Signature: X____Date___/____/___________
Relationship: ________________________________ (Consent valid 1 year; if not dated, valid from one year of date received)

HUMBOLDT PARK HEALTH
ADVANCING HEALTH EQUITY

Tuberculosis (TB) Risk Assessment*

Child's Name: ____ Date of Birth: __________________________

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue)? If YES, circle symptoms □Yes □ No
2. Has your child been exposed to anyone with tuberculosis disease? □Yes □ No
   If yes, who? _______________________________________And when? ___________
3. In what country was the child born? ____
   a. If born outside of the US, when did he/she arrive in this country: ______________________
   b. If born outside of the US, has he/she ever been given the BCG vaccine? □Yes □ No □ Unsure
4. Has the child lived or traveled to a country outside the US for more than 1 month? □Yes □ No
   If yes, what country? __________________When? __________________How long? ______
5. Has anyone living with the child come to the US from another country? □Yes □ No
   If yes, who, what country and what year? ____
6. Does your child spend time with anyone who, in the last 5 years, has been homeless, in jail, in a homeless shelter, is a migrant farm worker, uses illegal drugs, or has HIV? □Yes □ No
7. Has the child/teen ever been in jail? If yes, when? ____ □Yes □ No
8. Does the child have a history of immunosuppressive disease or take any medications that might cause immune-suppression (for example: cancer, sickle cell disease, lupus, HIV)? □Yes □ No
   If yes, what? ____
9. Has your child received a test for TB (blood test, skin test or Chest x-ray)? □Yes □ No □ Unsure
   If yes, When? ______________Results: □normal □abnormal
10. Has your child ever had tuberculosis? If yes, when ___________________ □Yes □ No □ Unsure

X __________________________ (Parent Printed Name)   X________________________________ (Parent Signature)   X __________________ (Date)

Interpretation (For use by clinic staff only):

Reviewed by: _______________________________________ Date: ___________________

Is the child at risk for TB? Yes No

□ Referral for Skin Test (PPD) □ Referral for CXR □ Referral for blood work

Humboldt Park Health Care-A-Van

1044 N Francisco Ave, Chicago, IL 60622

careavan@hph.care, (773) 292-2629

*Answers on this form will only be used to determine your child's risk for health problems, especially TB - a lung disease that is more common in some countries and in people with immune system problems.

HUMBOLDT PARK
HEALTH
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Pediatric **Care-A-Van**

The Humboldt Park Health **Pediatric Care-A-Van** is an initiative that delivers preventive medical care to underprivileged children in the Chicago area. This fully-equipped mobile health unit operates within the city, visiting public and parochial schools, day care centers, and community organizations. **Its primary objective is to provide free health screenings and comprehensive medical services to school-age children, promoting their well-being and ensuring a healthier future.**

Our services include:

- Physical Exams
- Hearing & Vision Screening
- Lead Testing
- Vaccines
- Hemoglobin Testing
- Vital Signs
    - Blood preasure, weight, etc
- TB Risk Assestment

Our mobile unit reaches children within our communities:

- For children ages 0 - 22
- All of our services are **free of cost**
- No Insurance required
- Our team speaks English & Spanish
- Free Vaccines if eligible (Medical card or no insurance)

If your school or organization is interested in having HPH's Pediatric Care-A-Van Unit visit, please email us at **careavan@hph.care**

www.hph.care | 1044 N Francisco Ave, Chicago IL 60622 | (312) 824-6765

HUMBOLDT PARK HEALTH
ADVANCING HEALTH EQUITY

Chicago Public Schools

Dear Guardian,

Humboldt Park Health is working with your school to provide health services for your child/student. If you have a regular doctor, dentist or clinic that you like to go to, great! We want you and your child/student to go to a place that works for you. We also know that getting your child to the clinic or dentist can be hard. We bring a team of health professionals to your child's school/site to provide services like lead and hemoglobin testing, hearing and vision screening, school physicals, sports physicals, basic dental services, and vaccines. These services do **NOT COST** you or your family. Having insurance is **NOT** required! If you would like your child/student to receive these health services, please fill out the forms (listed 1-4) and return them to the school/site. This letter, as well as the Notice of Privacy Practices, is for you to keep in case you have questions.

1. Humboldt Park Health Pediatric Mobile Services Consent: This form allows your child/student to be seen by the Mobile Services Team. **Your child/student can only receive services if this form is completed and signed**.
2. CPS Consent and Release of Liability: This form is required by Chicago Public Schools and allows the school to communicate with us about the services your child/student may need.
3. Tuberculosis (TB) Risk Assessment: This questionnaire helps us decide if your child/student is at risk for TB – an infection in the lungs. It is a required part of the school physical. Answers on this form will only be used to determine health risk.
4. Photo/Video Release Form: This form is not required, but is strongly encouraged. It allows us to highlight what we do so that we can continue to provide services at no cost.

By filling out these forms, you are giving your consent for the entire school year, which means your child/student may be seen by the Mobile Services Team more than once. How we use your information and your rights are listed in the Notice of Privacy Practices (attached). If you wish to withdraw your consent at any time, please contact the Mobile Services Team (number below) or in writing (address in Notice of Privacy Practices). Consent will remain valid until your withdrawal is confirmed by a HPH Mobile Services employee. If you do not want your child to receive vaccines or dental services, please mark "OPT-OUT" boxes on consent form. We cannot accept individual edits or cross-out marks on consent. If you would like to speak with a member of our team prior to returning your consent, please call: (773) 292-2629.

What to Expect:

We will review your child/student's health information from the school and ICARE (Illinois database for vaccine records) to confirm what your child/student may need. It is very important that the school has the most current health and vaccine records. If your child/student has NO vaccine records available at the time of the visit, we will not give any vaccines unless you write a note on the consent to restart the vaccine schedule. We follow the Center for Disease Control and Prevention (CDC) recommended vaccine schedule. **After we see your child/student, we will give them information about what was provided by the Pediatric Mobile Services Team to take home. Please ask your child/student for this paperwork, so that you know exactly what happened during his/her visit(s).** We will also include information that you may need such as how to get eye glasses or how to find a dentist. **We will give the school the forms that are required by them and a summary of the services we provide.**

Information on Vaccines:

Vaccine Information Statements (VIS) are available in multiple languages on this website: https://www.cdc.gov/vaccines/hcp/vis/current-vis.html. If you would like a paper copy *prior* to your child's visit, please call the Mobile Services Team at 773-292-2629. We give vaccines to children up to age 19 who qualify for the Vaccines for Children program, as verified by state records. Vaccines include: Dtap-Infarix, Td-Tenvac, Tdap-Boostrix, Hepatitis A-Havrix, Hepatitis B-Engerix, Hib - Pentacel, HPV-Gardisil, Influenza, MMR, Meningococcal-Menactra and Men-B (Bexsero), Pneumococcal-Prevnar, Inactivated Polio, and Varicella (combination vaccines also available: Kinrix, ProQuad, Pediarix and Pentacel). **Your child will only receive the vaccines that are due based on the information provided to us by the school/site and ICare**. You always have the option to say that you do not want a specific vaccine on the consent. Many of the vaccines we give are required for your child to stay in school. We also give recommended vaccines (Hepatitis A, HPV, Men-B, and flu) because they are important for keeping your child healthy and may someday be required by school/site. Records of services provided will be given to your child on the day of services (including vaccine information).

Again, we at Humboldt Park Health are here to assist you and your family. If you have any questions or concerns, please contact your school or call us directly at (773) 292-2629. Thank you!

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NOTICE OF PRIVACY PRACTICES

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

PROTECTED HEALTH INFORMATION

Information about your health is private and it should remain private That is why this healthcare institution is required by Federal and State laws to protect the privacy of your health information We call it "Protected Health Information" (PHI)

Staff members, employees and volunteers of this hospital/ facility must follow legal regulations with respect to:

- How we use your PHI
- Disclosing your PHI to others
- Your privacy rights
- Our privacy duties
- Contacts for more information, or if necessary, a complaint

USING OR DISCLOSING YOUR PHI

For Treatment
During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor, or we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures

For Payment
After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan, or your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid

For Healthcare Operations
Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. We might use the PHI from real patients in education sessions with medical students training in our hospital Other uses of your PHI may include business planning for our facility or the resolution of a complaint We may disclose your information orally, via fax, on paper, or through secure electronic messages and health information exchanges (HIEs) When using PHI for purposes that do not require patient identifiers, we redact identifying information as appropriate

Special Uses
Your relationship to us as a patient might require using or disclosing your PHI in order to

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

Required or permitted uses and disclosures

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances, which protect your privacy

We may also use or disclose your PHI:

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence
- To government regulators or agents to determine compliance with applicable rules and regulations
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining causes of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an Institutional Review Board, has determined that there is a minimal risk to the privacy of your PHI
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers' compensation program
- When properly requested by law enforcement officials, for instance in reporting gunshot wounds, reporting a suspicious death or for other legal requirements
- If we reasonably believe that use of or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities
- In connection with certain types of organ donor programs

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

Your right to request limited use or disclosure

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request If we do agree to your request, we must abide by the agreement.

Your right to confidential communication

You have the right to receive confidential communication from the hospital at a location that you provide You must provide us with the other address in writing and explain if the request will interfere with your method of payment.

Your right to revoke your authorization

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

Your right to inspect and copy

You have the right to inspect and receive a copy of your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal We may charge a reasonable fee for copying your records

Your right to amend your PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us We may refuse to make the amendment and you have a right to disagree in writing If we still disagree, we may prepare a counter-statement Your statement and our counter-statement must be made part of our record about you.

Your right to know who else sees your PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and healthcare operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed. Contact the Medical Records/Health Information Management Department at 773-292-5966 to request an accounting of disclosures

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice However, we reserve the right to change this notice and our privacy practices when permitted or as required by law If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in a place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations

OUR PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGES

We participate in the MetroChicago Health Information Exchange (MetroChicago HIE) to make patient information available electronically to participating hospitals, doctors and other authorized users. We may also receive information about patients from other participants and authorized users in the MetroChicago HIE. In the future we may participate in additional regional, state, or federal HIEs as they are developed.

We expect that using HIEs will provide faster and more complete access to your information so we can make better informed decisions about your care As described below, you can elect to opt-out and not allow your medical information to be available through any HIE. It is not a condition of receiving care

The MetroChicago HIE has been structured to comply with federal and state privacy and security laws Use of MetroChicago HIE is limited to physicians, hospitals, health plans, accountable care organizations, and other authorized users who confirm that they will comply with these laws

Health information disclosed to MetroChicago HIE may include information regarding your demographics, problem list, diagnosis, treatments, allergies, medications, radiology, and lab information. However, if you received alcohol or substance abuse services from certain treatment centers, that information generally will be excluded from MetroChicago HIE

Unless you opt-out of MetroChicago HIE, your mental health or developmental disability information (such as diagnosis and medications), HIV/AIDS information, and genetic information (such as test results) may be available to participants and authorized users of the MetroChicago HIE. For more information about how information may be disclosed to MetroChicago HIE and how you may opt-out, please ask registration staff for a copy of the MetroChicago HIE Notice to Patients and Frequently Asked Questions. Additional information is also available at http://www.mchc.com/hie-optout

RIGHT TO OPT-OUT TO MAKE YOUR HEALTH INFORMATION UNAVAILABLE THROUGH HEALTH INFORMATION EXCHANGES (HIEs)

If you do not want your medical information to be available through HIEs, please contact a staff member in our registration or medical records departments to receive the applicable Opt-Out Form and return it to us

For the MetroChicago HIE, approximately 24 hours after we process your request, your health care providers will no longer be able to view your medical information through the MetroChicago HIE. Your opt-out will apply to all information in the MetroChicago HIE, even in an emergency This means that it may take longer for your health care providers to get medical information they may need to treat you.

Even if you opt-out of all HIEs, legal requirements (such as public health reporting) may still be fulfilled through HIEs.

If you opt-out and later decide to reverse that decision, please contact us for a form to reverse your opt-out Your health information from the period during which you had opted-out may be available through MetroChicago HIE and other HIEs after you reverse your opt-out.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary

If you have questions about this notice or wish to file a complaint with us, you may contact:

Privacy Officer
Humboldt Park Health
1044 North Francisco Avenue
Chicago, Illinois 60622
773-292-8200

To file a complaint with the Secretary of Health and Human Services, write to:

200 Independence Avenue, S.E., Washington, D.C. 20201.
877-696-6775

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