Morgan Street Clinic

Acknowledgment of Notice of Privacy Practices

My signature below indicates that I have been given an opportunity to read the Notice Of Privacy Practices for the **Macoupin County Public Health Department**, and to have any questions answered before signing.

Signed: _____ Date: _____

Printed Name: _____

If signed by someone other than the patient, please indicate relationship to patient:

( ) Parent or guardian of minor patient

( ) Guardian or conservator of an incompetent patient

( ) Beneficiary or personal representative of deceased patient

Consent to Release Information to Designated Family Member or Caregiver

The names listed below are allowed to have information released to them from Macoupin County Public Health Department with the undersigned consent.

_____	_____
Name to receive information and relationship	Type of information **not** to release
_____	_____
Name to receive information and relationship	Type of information **not** to release
_____	_____
Name to receive information and relationship	Type of information **not** to release

This consent remains in effect for one (1) year period and will be updated and signed on a yearly basis or as needed per patient request. This consent may be revoked at any time upon written request.

FOR OFFICE USE ONLY:

Employee Signature: _____ Date: _____

If patient or patient's representative refuses to sign this Acknowledgment:

( ) Efforts to Obtain: _____

( ) Reason patient refused to sign: _____

Morgan Street Clinic

1115 E. Morgan Street
Carlinville, IL 62626

CONSENT TO TREATMENT FOR A CHILD

Maple Street Clinic requires that all parent/legal guardians bring their child to their first appointment. This is necessary to complete all forms and to sign consent for treatment. Consent to treatment allows those names listed to bring the child to our facility for treatment. However, a parent/legal guardian must bring the child to any appointment requiring an extraction in dental or a medication change in behavioral health. The below named individual(s) will provide information regarding my child's health, allergies, immunization contraindications, previous reactions to immunizations, and all medication currently being taken. The staff at Maple Street Clinic &School-linked Health Center has my permission to treat my child and/or provide all needed immunizations, dental, medical, behavioral health care.

I understand that this form must be updated once per year.

This consent is effective for one year. After one-year consent must be renewed.

Please sign the following consent if your child may be brought to his/her appointment by another adult (over 18 years of age).

I,_____, hereby give my consent for treatment and/or immunizations of
(Parent/Legal Guardian)

_____DOB_____ by the staff of Maple Street Clinic.
(Child's name) (Child's birthdate)

I give the consent for the following adults to bring my child to his/her medical, dental, or behavioral health appointments:

1. _____
(Name and Relationship to Child)

2. _____
(Name and Relationship to Child)

3. _____
(Name and Relationship to Child)

_____ _____
(Signature of Parent or Legal Guardian) (Date)

_____ _____
(Witness) (Date)

4/30/2018

Morgan Street Clinic School-Linked Health Center

Patient Name: _____ Date of Birth: _____

A complete range of services are:

- Well child exams complete with appropriate immunization, laboratory test, and review of future child health topics such as developmental or social milestones.
- School physicals
- Sports physicals
- Immunizations and TB skin tests
- Management of chronic conditions (Asthma, Diabetes, ect.)
- Emergency care and referrals
- Treatment for illnesses and injuries
- Help with Medications
- On-site simple lab test (Hemoglobin, blood sugar, lead, lipid profile, ect.)
- Health education and counseling
  (abstinence, nutrition, hygiene, risks, safety, and self-esteem)
- Medical, Dental, Behavioral Health, and Social Service referrals
- Routine dental care including extractions and sealants

Parental Consent

The above-named student has my consent to receive services offered by the Macoupin County Maple Street Clinic School-Linked Health Center located in Gillespie, IL. I have been informed of and understand the scope of services to be provided to the student.

I also consent to the release of relevant health information to the Macoupin County Maple Street Clinic School-Linked Health Center in order to facilitate evaluation of my child's health needs. I further authorize the School-Linked Health Center to release information regarding my child's treatment to third-party payers or others for the purposes of billing, program management, and evaluation in accordance with federal and state laws and regulations regarding confidentiality. I further authorize my child's school district, _____, to release to the school-Linked Health Center regarding my child's address and phone number for the purpose of maintaining the School-Linked Health Center's database.

I understand that I may revoke this consent in writing at any time, but that revoking this consent will not cancel what was done before I revoked the consent. I also understand that I have the right to refuse services at any time.

For minor participants:

_____ _____
(Signature of Parent/Legal Guardian ONLY) (Date signed)

For students who are legally permitted to give consent for him/herself:

_____ _____
(Signature of Student) (Date signed)