Macoupin County Public Health Department

Maple Street Clinic

Dear Parents,

A **FREE** Dental program and other services are being provided by Maple Street Clinic, Macoupin Co. Public Health Dept., and the Illinois Department of Healthcare and Family Services for **ALL** children in your school. Dental services may include an exam, cleaning, fluoride treatment, and sealants(a protective coating to seal out food and bacteria that cause decay). Other services include school and sports physicals, immunizations, sick/urgent care, and counseling. In order for your child to receive these services, please fill out this form **completely** and return to your child's school nurse.

Please print **in ink** and answer all of the following questions:

SCHOOL: _____TEACHER_____GRADE_____

CHILD'S NAME: _____ BIRTHDATE: _____GENDER: M / F

ADDRESS: _____ CITY/ZIP _____

PHONE: _____ HOUSING: ☐**Public Housing** ☐**Rent** ☐**Own**

EMAIL ADDRESS:_____

RACE: Please check all that apply for your child

☐Asian ☐Black ☐Hispanic ☐Native American ☐White ☐Other

Your child does not have to be enrolled in free/reduced lunch or Medicaid to receive dental services at school

Does your child qualify for free or reduced lunch? ☐**Yes** ☐**No**

Is your child enrolled in the "All Kids" or Medical Card program? ☐**Yes** ☐**No**

If **YES**, what is your child's recipient number (9 digits): ____-____-____-____-____-____-____-____-____

HEALTH HISTORY

Has your child had any serious health problems? ☐**YES** ☐**NO**

If **YES**, please explain_____

Does your child have any allergies? ☐**YES** ☐**NO**

If **YES**, please explain_____

Is your child taking any medications at this time? ☐**YES** ☐**NO**

If **YES**, please list_____

Emergency Contact: _____ Phone number: _____

FREE** transportation to Maple Street Clinic or MCPHD in Carlinville provided by MCPT for your next visit

please call 1-877-600-0707 for a ride

The above is true and correct to the best of my knowledge. All clients have the right to treatment by Macoupin County Public Health Department and Maple Street Clinic without discrimination to age, race, color, religion, sex, sexual orientation or national origin. I accept full responsibility for my care and treatment and release Maple Street Clinic and staff of any and all liability for any adverse results that may occur due to my refusal to follow the recommended plan of treatment. I authorize Macoupin County Public Health Maple Street Clinic to provide service to me and to release necessary information to bill, process, and receive payment of Medical/Behavioral/Dental Benefits (private insurance, Medicare, Medicaid, etc), for Professional Services rendered. I give permission for IDPH, QA audits to be performed and providers to return to check my child's sealants and for the school nurse and providers access to the child's dental record.

Parent/Guardian Signature: _____Date:_____

Print Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____Relationship_____

Macoupin County Public Health Department

Maple Street Clinic

Maple Street Clinic School-Linked Health Center

Patient Name: _____ Date of Birth: _____

Available services include, but are not limited to:

- Physical examination, health assessments, screening for health problems
- Diagnosis and treatment of acute illness and injury
- Immunizations, Lead and TB skin tests
- Diagnosis and management of chronic illness
- Health education and promotion. Outreach health promotion/prevention workshops will be offered
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Wellness promotion including smoking cessation, nutrition, weight management
- Reproductive health care including: gynecological examinations with PAP smears, STD education, testing and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
- Mental Health counseling services
- Dental examination and treatment
- Referrals to other linkage agencies for services not provided at the School Health Center

Please select the service(s) you (parent or legal guardian) give consent for:

Dental	**Medical**	**Mental Health**
___All services below	___All services below	___Counseling
___Sealants	___Immunizations	___**Decline services**
___Fluoride	___School/sports physicals	
___Prophy(cleaning)	___Treatment for acute illness/injury	
___Exams & treatment	___Reproductive health care	
___**Decline services**	___**Decline services**	

Parental Consent **PUBLIC ACT100-378 Consent by Minors to Health Care Services Act**

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 which may be provided to the student. I understand that under Illinois law, a minor age twelve (12) and over has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. I understand that if my child is 12 or older and were to receive mental health/substance abuse services at Macoupin County Maple Street Clinic, he/she may receive up to eight (8) therapy sessions without my consent. I am aware that a separate parental consent form will need to be signed for substance abuse services. By law, a child under the age of twelve (12) will be allowed to receive mental health/substance abuse services without parental consent.

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.

_____ _____

(Signature of parent/guardian) (Date signed)

_____ _____

(Signature of patient 12 yrs or older) (Date signed)