Maple Street Clinic
109 E. Maple, Gillespie, IL 62033
217-839-1526 ~ Medical/Behavioral
217-839-1538 ~ FAX
217-839-4110 ~ Dental

Macoupin County Public Health Department

Morgan Street Clinic
1115 Morgan St., Carlinville, IL 62626
Medical/Behavioral ~ 217-854-3692
FAX ~ 217-930-2293
Dental ~ 217-854-6823

Columbian Blvd. Dental Clinic ~ 125 W. Columbian Blvd. South ~ Litchfield, IL 62056 ~ 217-250-2360 (p) ~ 217-250-2365 (fax)
St. Francis Way Clinic ~ 805 St. Francis Way ~ Litchfield, IL 62056 ~ 217-250-2380 (p) ~ 217-250-2385 (fax)
Health & Wellness Center ~ 118 W Chestnut St ~ Gillespie, IL 62033 ~ 217-839-7200 (p) ~ 217-839-7201 (fax)

Dear Parents,

A convenient program will soon be available in your child's school. Maple Street Clinic, Morgan Street Clinic, Columbian Blvd Dental Clinic, Macoupin County Public Health Department, and the Illinois Department of Healthcare and Family Services have been arranged for certain dental, medical and counseling services for eligible children. Services may include a school or sports physical, immunizations, sick/urgent care, dental care, and counseling. In order for your child to receive these services, please fill out this form and return it to your child's school nurse. If you or any family member are in need of these services, they are also available for adults at our facilities in Carlinville, Gillespie or Litchfield.

Please print IN INK and answer ALL the following questions:

SCHOOL: _____ TEACHER: _____ GRADE: _____

CHILD'S NAME: _____ BIRTH DATE: _____ GENDER: M / F

ADDRESS: _____ CITY/ZIP _____

PHONE: _____ EMAIL ADDRESS: _____

ETHNICITY: ❑ **Hispanic** ❑ **Non-Hispanic** ❑ **Other** ❑ **Many** HOUSING**:** ❑ **Public Housing** ❑ **Rent** ❑ **Own** ❑ **Other**

RACE: Please check all that apply for your child: ❑ **Asian** ❑ **Black** ❑ **Hispanic** ❑ **Native American** ❑ **White** ❑ **Other**

Does your child qualify for free/reduced lunch? ❑ Yes ❑ No

Does the patient have (check all that apply): ❑ Private Insurance ❑ Medicaid/Medicaid Managed Care ❑ No Insurance

- If Medicaid/Medicaid Managed Care, what is the recipient number (9 digits):_____ - _____ - _____ - _____ - _____ - _____ - _____ - _____ - _____
- If Private or Medicare/Advantage Insurance,

  Company Name: _____

  Policy#: _____ Group#: _____

  Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

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 currently? ❑ Yes ❑ No If **YES**, please list _____

Emergency Contact: _____ Phone number: _____

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, Morgan Street Clinic 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 MCPHD, Maple Street Clinic, and Morgan 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, Morgan Street Clinic and 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 or medical record.

Parent/Guardian Signature: _____ Date: _____

Print Parent/Guardian Name: _____ Parent/Guardian Date of Birth: _____

Relationship _____

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, Hemoglobin, 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 by a licensed dentist or Public Health Dental Hygienist
- 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
___All services below
___Sealants
___Fluoride
___Prophy(cleaning)
___Dental X-rays
___Exams & treatment
___Decline services

Medical
___All services below
___Immunizations
___School/sports physicals
___Treatment for acute illness/injury
___Reproductive health care
___Decline services

Mental Health
___Counseling
___Decline services

Please give my child vaccinations that will make him/her compliant with Illinois State School Requirements.

Parent/Guardian_____

In addition to the Illinois State School Required Immunizations, please give my child vaccinations that are recommended by the American Pediatric Association. This authorization does not include the COVID-19 vaccine.

Parent/Guardian _____

By signing below, I consent for the above selected dental services to be provided by a Public Health Dental Hygienist.

I understand the services received are meant for those who otherwise would not have access to services. These services do not take the place of a regular dental examination given at a primary dental office. I understand I will still need a thorough comprehensive exam by a licensed dentist.

Parent/Guardian _____

Parental Consent PUBLIC ACTl00-378 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 School-Linked Health Center, Gillespie, IL and Morgan Street School-Linked Health Center, Carlinville, 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 Maple Street School - Linked Health Center and Morgan Street School-Linked Health Center, 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 not 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 and Morgan Street Clinic 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**_____