Erie Family Health Center | Centro de Salud Erie
Trust. Heal. Care.

Erie Lake View School Based Health Center

The Erie Lake View School Based Health Center is made possible through a partnership between Amundsen High School, Erie Family Health Center, and Advocate Illinois Masonic Medical Center/Advocate Medical Group.

The goal of the Health Center is to improve the physical and emotional health of students attending Amundsen High School, and to teach them life-long, positive health behaviors by providing quality, comprehensive primary healthcare. **Students must have a signed parental/guardian or confidential consent form on file before they can receive services at the Health Center.**

The Health Center is located on the first floor of Lake View High School. Health Center staff includes licensed Nurse Practitioners, Physician Assistants, Family Physicians, Clinical Psychologists and other supporting staff. The Health Center is open Monday through Friday from 8:00am-4:00pm, opening at 10:00 AM on Wednesdays.

If your child is uninsured, there may be a minimal $3.00 sliding fee to receive services. We have trained staff on-site that can assist your family with enrolling in programs that offers Illinois uninsured children comprehensive healthcare.

The staff of the Health Center considers parental involvement vital. Every student is encouraged to involve parent(s)/guardian(s) in healthcare decisions. However, confidentiality between the student and healthcare providers will be ensured in specific service areas designated by the law, and will not be discussed with parent(s)/guardian(s) unless agreed upon by the student.

Services available will include but are not limited to the following:

Health Assessment and Physical Exams • Routine physicals and health screenings • School, sports and employment physicals	**Nutrition Counseling** • Weight Management • High blood pressure, anemia, and high cholesterol • Eating disorders
Laboratory Services • Throat cultures • Diabetes screens • Routine blood tests • Urine tests • Pregnancy tests • Rapid HIV testing • Blood pressure screening • Immunizations** • Tuberculosis testing	**Counseling Services** • Assessment of stress, depression and adjustment difficulties • Assessment of alcohol & drug problems • Counseling for emotional & behavioral issues • Individual, group & family counseling
Reproductive Health Services • Abstinence counseling • Education/diagnosis/treatment for sexually transmitted infections • Menstrual problems • Contraceptive counseling/exams/prescriptions • Pregnancy services-tests, prenatal care	**Diagnosis/Treatment of Minor Illness & Injury** • Infections • Earaches • Sore throats • Sprains, cuts, burnps • Flu
Diagnosis/Management of Chronic Illness • Asthma • Diabetes	**Referrals/Follow Up** **Health Education Programs** **Group/Classroom Education**

**Information surrounding immunizations given will be submitted to I-CARE, the Illinois Comprehensive Automated Immunization Registry Exchange. The primary goal of I-CARE is to increase the immunization coverage level of Illinois' children. By giving your child consent to receive immunizations, you are also consenting transfer of information to I-CARE.

IF YOU HAVE ANY QUESTIONS OR CONCERNS, PLEASE CALL (312) 666-3494 or FAX (773) 327-9189.
Visit our website at www.eriefamilyhealth.org.

PATIENT INFORMATION

Full Name:

Date of Birth: **Sex: F_____ M_____**

Grade: **Classroom:**

PARENT/GUARDIAN CONTACT INFORMATION

Name: **Date of Birth:**

Relationship: □ Parent □ Legal guardian (not parent) □ Grandparent □ Other relative (specify):
(Check all that apply) □ Foster Parent □ Other (specify):

Street Address: **Apartment No:**

City: **Zip:**

Home Phone: ( ) - **□ ___ Check here if no home phone is available**

Cellular Phone: ( ) - **□ ___ Check here if no cellular phone is available**
Is it okay to text you at this number? □ Yes □ No

Work Phone: ( ) - **□ ___ Check here if no work phone is available**

Email:

What method would be the best to contact you? Please check one:
Home_____ Cell_____ Work_____ Email_____

EMERGENCY CONTACT INFORMATION

Name:

Relationship to patient: □ Parent □ Legal guardian (not parent) □ Grandparent □ Other relative (specify):
(Check all that apply) □ Foster Parent □ Other (specify):

Emergency Phone: ( ) -

BACKGROUND INFORMATION

Primary Language: English_____ Spanish_____ Polish_____ Other_____

Military Status: Veteran_____ Non-Veteran_____

Housing Status: Own/Rent_____ Homeless Shelter_____ Doubling Up (living with family or friend_____

Prefer not answer_____ Other_____

Ethnicity: Hispanic or Latino_____ Not Hispanic or Latino_____ Prefer not to answer_____

Race: Which category best describes your race?
____ Asian
____ Black or African American (including Black or African American of Latino/Hispanic descent)
____ American Indian/Alaska Native (including American Indians or Alaska Natives of Latino/Hispanic descent)
____ White (including Whites of Latino/Hispanic descent)
____ More than one race
____ Unreported
____ Prefer not to answer

HEALTH INSURANCE

Medicaid and other insurance carriers may be billed for services provided. If you are insured, please record insurance information below and provide a ***copy of your current insurance card***.

DO YOU HAVE HEALTH INSURANCE? ____YES ___NO

If you do, please compete the following:
State Insurance: ____AllKids ____Medicaid (Managed Care Plan) Name of Plan:_____

Private/Commercial: _____HMO _____PPO Name of Insurance Company: _____
Name of Insured (i.e. parent/guardian): _____
S.S. # __ __ __- __ __ - __ __ __ __ Policy #_____ Group #:_____

If you currently do not have insurance, please fill out the information below:
How many people are currently residing in your household? _____
Total household income: Monthly: _____ Yearly: _____

Other Provider Information

Does your child have a regular/primary health care provider? **No** **Yes**

If yes, name of doctor:_____ Phone: (_____)_____

Name of clinic:_____

Provider address:_____

Is your child under the care of a medical specialist? **No** **Yes**

If yes, medical condition:_____

Name of doctor:_____ Phone: (_____)_____

Name of clinic:_____

Provider address:_____

Medical/Social History

Is your child allergic to any medications?	**___No ___Yes** **Please list:**
Is your allergic to any foods?	**___No ___ Yes** **Please list:**
Has your child been hospitalized for any reason?	**___No ___ Yes** **If yes, for what condition and when?**
Has your child ever had operations/surgeries?	**___No ___Yes** **Please explain:**_____
Does your child have any medical conditions?	**___No ___ Yes** **If yes, what condition?**
Is your child taking any medications?	**___No ___Yes If yes, for what condition?** **Name of medication(s): _____** **Dosage(s): _____** **Routine: _____**
Has your child had any of the following Childhood Illnesses?	**___Chickenpox ___Measles ____Mumps ____Rubella**

Family/Child's History

	Name/Age	Additional siblings	Name/Age
Mother:			
Father:			
Siblings:			

Family Medical History

	Child	Child's Family		Child	Child's Family
Asthma			Eye/Vision problems		
Anemia			High Blood Pressure		
Bleeding			High Lead		
Cancer			Kidney Disease		
Dental problems			Developmental Disabilities		
Diabetes			Skin/Eczema		
Epilepsy			Sickle Cell		
Emotional Problems/Suicide Attempts			Tuberculosis/ Positive PPD		

Release of Information

I give permission to the Erie Family Health Center to exchange protected medical information between Erie Family Health Center and Chicago Public Schools. This authorization shall remain in effect throughout the student's enrollment unless revoked. The consent does not include releasing privileged information concerning treatment for drug and alcohol use, sexually transmitted information, HIV status or mental health issues.

_____ _____ _____ _____

Signature of Parent/Guardian Date Signature of Student (12 or older) Date

ERIE FAMILY HEALTH CENTER SCHOOL HEALTH PROGRAM IMMUNIZATION CONSENT SHEET

Under Federal Law, it is now required that parents sign specifically to authorize immunizations that their minor children receive and parents must also receive written information about each immunization.

If your child receives immunizations at an Erie Family Health Center school-based site, your child will be bringing home written information about the immunizations that he/she will receive. If you have any questions about the written information on the immunizations, please feel free to call (312) 666-3494 to reach the Erie Family Health Center.

In order to avoid frequent visits to the Health Center to provide your signature for authorization, we have designed this form for you to give consent in advance, if you would like. By signing below, you give consent for your child to receive immunizations if he/she is due for any of them.

Please attach a copy of any immunization records you have for your child.

With my signature, I give consent for my child _____to have
(Child's Name)
immunizations if he/she is in need of them:

A. **TD/Tdap (Tetanus booster shot)**
B. **MMR (Measles/Mumps/Rubella) (2 doses required)**
C. **IPV (Polio)**
D. **Hepatitis A**
E. **Hepatitis B**
F. **Varicella (Chickenpox) (2 doses required)**
G. **Meningococcal (1 dose for 6th grade; 2 doses for 12th grade)**

The following vaccines below are also available at the Erie Family Health Center

H. **Influenza Vaccine (Flu) *** ***Not required; initial here if your child should NOT receive*****: _____**

I. **Gardasil (HPV)** * ***Not required; initial here if your child should NOT receive:*** **_____**
Recommended for both males and females ages 9 -26 to prevent cervical cancer and other less commom cancers which are caused by HPV (human papillomavirus). In addition to cancer, HPV can also cause other health related problems, such as genital warts.

_____ _____

Parent/Legal Guardian Signature Date

ERIE FAMILY HEALTH CENTER SCHOOL HEALTH PROGRAM
CONSENT FORM

Parent/Legal Guardian Consent for Care:

I, (or the patient named above) hereby consent to receive the services offered by Erie Family Health Center's School-Based Health Program. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in the treatment and I consent to such student involvement in the care. This consent is valid for the duration of the above named minor's enrollment in the CPS/EFHC site. I understand that I may withdraw my consent at any time.

All students under the age of 18 are eligible for services if they have obtained written parental consent or if they are otherwise permitted under Illinois law to consent on their own behalf to such care. In addition, a parent, legal guardian, or student who is permitted under Illinois law to consent on his/her own behalf has a right to refuse any health care services.

Comprehensive medical care includes the same services my child could receive in a doctor's office or clinic. Such services may include, but are not limited to:

- **School and sports physicals**
- **Immunizations** * *please review immunization consent form on previous page**
- **First aid for minor injuries**
- **Examination, diagnosis, and treatment of complaints/acute medical problems/illnesses being identified by my child.**
- **Diagnosis and treatment of illnesses, such as: diabetes, high blood pressure, etc.**
- **Medication administration**
- **Application of fluoride varnish (used to strengthen your child's teeth)**
- **Delivery of prescription medications**
- **Counseling services include support that a social worker/counselor would provide the student related to classroom difficulties, substance abuse, and/or other adolescent development issues.**
- **Nutritional counseling**
- **Reproductive health services**
- **Laboratory services, such as blood or urine samples**

I understand that Health Center staff may request that I sign additional forms with regard to certain types of treatment or procedures for my child. I understand my child may consent to certain types of services, and that confidentiality between the student and the Health Center professionals will be ensured in specific areas designated by Illinois law, and will not be discussed with the parent/guardian unless the student agrees. I further understand that the medical records obtained by the Health Center are confidential.

I have read the above information and have had the opportunity to have my questions answered. I understand that I may revoke this consent at any time*. I do hereby give my consent for my child to receive services offered by Erie Family Health Center.

_____	_____	( ) _____
Signature of Parent/Guardian	Date	Area Code/Phone #

*Illinois State law requires a parent's or legal guardian's consent to provide medical treatment to a minor child except for family planning, sexually transmitted infection services, and certain mental health service when the minor is 12 years of age or older. (Consent by Minors to Medical Procedures Act [410 ILCS 210/0.01, 4, 5 et seq.; 325 ILCS 10/0.01 et seq.)

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: _____

Patient Date of Birth: _____

Date of Visit: _____

My signature on this form acknowledges that I have received a copy of Erie Family Health Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by Erie Family Health Center and my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

_____ _____

Patient's Signature Date

_____ _____

Signature of Patient's Representative (if patient is unable to sign or is a minor) Date

To be completed by Provider or Clinical Staff member if FORM IS NOT SIGNED

1. Was the patient provided a copy of the Notice of Privacy Practices?

☐ Yes ☐ No

2. Briefly describe the efforts made to obtain the patient's acknowledgement of receipt of the Notice and explain why the patient was unable or unwilling to sign this form:

_____

_____

_____

_____

ALL PATIENTS MUST RECEIVE A COPY OF THE NOTICE OF PRIVACY PRACTICES AS A FIRST ENCOUNTER.