Public Health
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Champaign-Urbana Public Health District

Champaign-Urbana Public Health District Children's Dental Clinic will visit your child's school again this year to provide dental services. **These services meet the State of Illinois requirement that all children in Grades K, 2nd & 6th show proof of a dental exam by May 15, 2015.**

Dental services include an exam, cleaning, fluoride, and dental sealants if needed. With parents' additional consent, services may also include simple fillings. All services are provided by Illinois Licensed Professional Dentists and Dental Hygienists, who follow strict Universal Infection Control Standards and maintaining the highest standards of dental care.

These services are available at no cost to you!

Please use ink to complete and sign the attached consent form and return to your child's school within the next 5 days.

Champaign-Urbana Public Health District Children's Dental Clinics **217-531-4279**	
Children's Dental Clinic 201 West Kenyon Road Champaign	Urbana School Health Center 1002 South Race Street Urbana

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SCHOOL DENTAL SERVICES CONSENT FORM

The State of Illinois requires a dental exam for children in Grades K, 2 & 6.
Your child's school has arranged for dental services at school, provided by
Illinois Licensed Dentists and Dental Hygienists with
Champaign-Urbana Public Health District Children's Dental Clinic & the Illinois Department of HFS.

These dental services are offered at no cost to you!

TO RECEIVE SERVICES, PLEASE COMPLETE BOTH SIDE OF THIS FORM, SIGN AND RETURN TO YOUR CHILD'S SCHOOL.

Please Print and use INK – not pencil. Please complete a separate form for each child.

☐ Yes, I would like my child seen for dental exam, cleaning, fluoride & dental sealants
(you will receive a report when this is completed)

☐ Yes, I would like my child seen for Simple Fillings, if available at school
(you will be contacted *before* this is scheduled)

Child's Name_____ **Date of Birth**_____/_____/_____ ☐ **Female** ☐ **Male**

School: _____ Grade: _____ Teacher: _____*(if known)*

Is this child in foster care? ☐ Yes ☐ No
If yes, only an exam can be done unless you attach current DCFS consent and physical.

Race ☐ Asian ☐ Black or African American ☐ American Indian or Alaskan ☐ Hawaiian or Pacific Islander ☐ White

Ethnicity ☐ Hispanic or Latin ☐ Non-Hispanic ☐ Prefer not to answer

What is your primary language? _____

Parent / Legal Guardian Name _____

Street Address _____ **City** _____ **Zip** _____

Home Phone Number: _____ **Other Phone Number:** _____

Does your child qualify for Free or Reduced Lunch? ☐ Yes ☐ No

Is your child enrolled in the Illinois Medicaid Program? ☐ Yes ☐ No

If yes, Include your child's Member ID number ☐☐☐☐☐☐☐☐☐
9 digit ID number next to child's name on card

Is your child covered by Dental Insurance ***other than*** Illinois Medicaid? ☐ No ☐ Yes, Name: _____

YOU MUST ALSO COMPLETE BOTH SIDES OF THIS FORM

Please check and medical condition that applies to your child:

☐ **NO KNOWN MEDICAL CONDITIONS**

- □ ADD, ADHD or related
- □ AIDS or HIV (Positive)
- □ Anemia or Blood disorders
  please list: _____
- □ Artificial Joints
- □ Asthma
  Requires use of nebulizer or inhaler?
  □ Yes □ No
- □ Autism
- □ Blood Transfusion, date: _____
- □ Cancer, Type: _____
- □ Cardiac Pacemaker
- □ Cerebral Palsy
- □ Chronic Stomach Problems
- □ Congenital (at birth) Heart Problems
- □ Damaged or Artificial Heart
- □ Other heart or cardiovascular diseases
  Type: _____
- □ Diabetes, Type:_____
- □ Epilepsy or Seizure Disorders
- □ Eczema
- □ Excessive Bleeding Problems or Disorder
- □ Fainting Spells
- □ Frequent Hives or Skin Rashes
- □ Hearing Impaired □ Vision Impaired
- □ Heart Murmur
  Required to pre-medicate? □ Yes □ No
- □ Heart Surgery or planning Heart Surgery
- □ Hemophilia
- □ Hepatitis, jaundice, or other Liver Disease
- □ High or Low Blood Pressure (please circle)
- □ History of Alcohol, Tobacco, or Drug use
- □ Kidney Disease
- □ Menstrual bleeding problems
- □ Physical Disabilities
  Please list:_____
- □ Pregnant
- □ Psychiatric, Mental Disabilities or Behavioral Problems
  Please list: _____
- □ Seasonal Allergies or Hay Fever
- □ Sickle Cell Anemia
- □ Sinus Problems
- □ Surgery, Chemotherapy or X-Ray treatments
  for growths or tumors or tuberculosis
- □ Tobacco or Drug Use: _____
- □ Venereal Disease, Type: _____
- □ Other diseases, conditions, or medical problems not listed above: _____

Please list all medications, oral contraceptives, supplements and multivitamins your child currently takes:

☐ **None** _____

Is your child allergic to any of the following? ☐ **NO KNOWN ALLERGIES**

□ Cephalexin (Keflex)	□ Aspirin	
□ Clindamycin (Cleocin)	□ Codeine	□ Iodine
□ Erythromycin	□ Ibuprofen	□ Latex (Gloves, etc.)
□ Penicillin / Amoxicillin / Augmentin	□ Tylenol	□ Sulfa or Sulfite Drugs
□ Other Antibiotic: _____	□ Other pain medications: _____	

"To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental provider of any changes in my child's medical status."

In signing this form, you give permission to treat your child and also verifies that you have received a copy of your Privacy Rights. This also gives permission for HFS and dental providers to return to your child's school to re-check and replace your child's sealants, if needed.

Parent/Legal Guardian Signature_____ **Date**____/____/_____

Dentist's Signature _____ **Date** ____/____/_____

Notice of Privacy Practices

Champaign-Urbana Public Health District
201 W. Kenyon Rd. Champaign, IL 61820

This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

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www.c-uphd.org

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

If you have any questions about this Notice, please contact our Privacy Manager at Telephone: 217-352-7961

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location within the practice, and if such is maintained by the practice, on it's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made, of your PHI, to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager. Contact information is provided under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices, and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Manager at:
Telephone: 217-352-7961

We will not retaliate against you for filing a complaint.

HHS Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Avenue, Suite 240
Chicago, Illinois 60601

Phone: 312-886-2359
TDD: 312-353-5693
Fax: 312-886-1807
Email: OCRComplaints@hhs.gov

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