UnityPoint Clinic
Methodist In-School Health

CONSENT TO TREATMENT

My student: _____ Birth date: _____School:_____
has my consent to receive services offered by **UnityPoint Health Methodist In-School Health**, contracted providers with Peoria Public School District 150**.**

☐ **YES** Continue completing form and sign.

☐ **NO** Stop here.

I understand that confidentiality between the student and the Health Center staff will be ensured in specific areas designated by Illinois and Federal law and will not be discussed with the parent/guardian unless the student agrees. I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services.

I also consent to the release of relevant health information to the Health Center from Peoria Public School District No. 150 in order to facilitate evaluation of my student's health. I authorize the Health Center to share only pertinent information regarding my student's health to school authorities so they may assist my student if necessary. I also consent for Peoria Public School District No. 150 to release to the Health Center and for the Health Center to have access to the complete student record of my student, including but not limited to any documents created by Peoria Public School District No. 150, pursuant to the *Illinois School Student Records Act*, 105 ILCS 10/1 *et seq*. as well as all documents and communication from a therapist, doctor, or hospital which may be deemed mental health records under the *Illinois Mental Health and Developmental Disabilities Confidentiality Act*, 740 ILCS 110/1 *et seq.*

_____(Initial) I hereby acknowledge the UnityPoint Health Methodist (MMCI) Notice of Privacy Practices was offered and/or received.

_____(Initial) I hereby acknowledge the UnityPoint Health Methodist Patient Rights and Responsibilities indicating the informed consent to have the ability to request and refuse treatment and to know what may happen if you refuse said treatment was offered and/or received.

Below is a list of services offered by the UnityPoint Health Methodist In-School Health Center

Unless otherwise noted, my signature below makes my student eligible for all services offered by the school based health center and I give permission that services provided will be in my child's best interest. Referrals to other agencies for services not provided at the Health Center will be made on behalf of my child.

- Complete physical examination (annual, school, or athletic)
- Immunizations
- Acute and chronic illness management
- First Aid and emergency services
- Age appropriate anticipatory guidance and screening
- Individual and group health education
- Testing, treating, educating, and referrals for sexually transmitted infections and reproductive services
- Treatment for conditions that cause absence from school (headache, cramps, etc)
- Family, group, and individual counseling
- Laboratory services
- Wellness Program, including nutrition and weight management

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ASSIGNMENT OF BENEFITS: I understand I may receive a bill for services provided. I assign to MMCI any benefits that may be payable to me or for the benefit of my student by any insurance company, HMO, health benefits organization, state or federal program, including without limitation, Medicaid, or other third-party payer, by reason of services and medications provided to my student whose name appears above. I authorize MMCI to apply for whatever third-party payers to make direct payment of benefits to MMCI.

RELEASE AND INDEMNIFICATION: I hereby irrevocably release the Board of Education of Peoria Public School District No. 150, its individual Board members, officers, agents, representatives, administrators, employees, and volunteers, and MMCI, and its officers, agents, representatives, administrators, employees, and volunteers, from any and all responsibility, liability, claims, damages, losses for personal injury, damages, accident, or illness incurred as a result of, arising from, or related to MMCI's treatment hereunder or the Board's release of information to MMCI. Moreover, I hereby waive, relinquish, and indemnify and hold harmless, the Board, its individual board members, officers, agents, representatives, administrators, employees, and volunteers, and MMCI, and its officers, agents, representatives, administrators, employees, and volunteers, from and against any and all claims, demands, suits, causes of action, whether known or unknown, past, present or future, including, but not limited to, any and all costs, expenses and fees, including but not limited to attorneys' fees, by reason of injury, death, illness, disability, or loss of or damage to person or personal property, arising out of, in connection with, or in any manner related to MMCI's treatment hereunder or the Board's release of information to MMCI.

Parent/Legal Guardian name: _____ Date: _____
(print full name)

Parent/Legal Guardian signature: _____

Relationship to the student: _____

UnityPoint Clinic

Today's Date_____ School_____

Child's Name_____Birthdate_____Age_____

Sex: M / F/ Self Identify:_____

Address_____City_____Zip_____

Mother's Name_____Birthdate_____Phone_____

Father's Name_____Birthdate_____Phone_____

Legal Guardian (if other than Parents)_____

Who Does the child live with?_____

Contact Information:

Mother's Employer_____ Work Phone_____

Father's Employer_____ Work Phone_____

Emergency Contact _____Relationship_____Phone_____

Alternate Emergency Contact 1._____Relationship_____Phone_____

2._____Relationship_____Phone_____

Child's Physician or Doctor's Office_____

Pharmacy_____ Location_____ Date of last Physical_____

Insurance Information:

_____Medicaid _____Kid Care _____Private Insurance _____Not Covered

Medicaid Number (9 digit)_____

Insurance Company_____

Name of Insured_____ Relationship to Student_____

List any medicine your child takes on a regular basis (include over the counter and herbals)

Medication	Dose	How Often?

Is your child allergic to any medication? Y / N If yes, please describe:

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Does your child have a LATEX allergy? Y / N

List of child allergies:_____

_____

Are your child's immunizations up to date? Y / N PLEASE PROVIDE US WITH A COPY

Does anyone in the child's home smoke cigarettes? Y/ N

List any hospitalizations, operations or procedures you child has had

Date	Describe

Has your child had any of the following conditions? Y / N Check all that apply

	Seasonal Allergies		Lead poisoning		Frequent Headaches
	Asthma		ADD/ADHD		Sickle Cell Anemia
	Heart Murmur		Learning Disabilities		Sickle Cell Trait
	Urinary Tract Infection		Constipation		Menstrual Problems
	Frequent Stomach pain		Bed Wetting over 6y		Sexually Transmitted Infection
	Seizures		Frequent strep throat		Premature Birth
	Eczema		Depression		Other:
	Eye Problems		Frequent Ear Infections		

Birth History: Birth weight_____ Premature? Y / N

Is your child: adopted? Y / N a foster child? Y / N

Please list any complications or problems experienced by the mother or infant during pregnancy or delivery?_____

_____

Family History: Please note any family history of the following conditions:

Condition	Relation to child	Condition	Relation to child
Seasonal Allergies		Kidney Disease	
Bleeding Gums		Thyroid Disease	
Asthma		Sickle Cell trait/Disease	
Cystic Fibrosis		Seizures	
Heart Disease		Mental Illness/Depression	
Death before age 50 (Reason if Known):_____		Arthritis	
High Cholesterol		High Blood pressure	
Diabetes		Urinary Tract Infection	
Cancer		**Other (explain)	

** Other illnesses, conditions, problems or concerns not listed above:

_____

_____

_____

Vaccination Consent Form

UnityPoint Health Methodist
In-School Health Program at Trewyn School

Student Name: _____

Birthday: _____**Grade:**_____**Teacher:**_____

Dear Parent or Guardian,

If your child is in need of any of the following vaccinations, can we administer these vaccines while at school? We would call to discuss them with you prior to administration.

Required:

_____ DTaP (Diptheria, Tetanus, & Pertussis)

_____ Hepatits B (Liver Disease)

_____ IPV (Polio)

_____ Menactra (Meningitis)

_____ MMR (Measles, Mumps, & Rubella)

_____ Varicella (Chickenpox)

_____ TDaP Booster (Tetanus, Diptheria, & Pertussis)

Recommended:

_____ Gardasil (HPV)

_____ Hepatitis A (Liver Disease)

_____ Influenza (Flu Shot)

Parent Signature: _____Date:_____

Phone Number: _____

If you have any questions please call the Trewyn Health Center at 671-0550.

UnityPoint Clinic

UnityPoint Health Methodist Staff - Trewyn
Sarah Peterson, APN, CPNP-BC
Brittney Field, CMA

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Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? yes ☐ no ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Technical content reviewed by the Centers for Disease Control and Prevention

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (8/19)

Information for Healthcare Professionals about the Screening Checklist for Contraindications to Vaccines (Children and Teens)

Are you interested in knowing why we included a certain question on the screening checklist? If so, read the information below. If you want to find out even more, consult the references in **Notes** *below.*

NOTE: For supporting documentation on the answers given below, go to the specific ACIP vaccine recommendation found at the following website: www.cdc.gov/vaccines/hcp/acip-recs/index.html

1. **Is the child sick today?** *[all vaccines]*

   There is no evidence that acute illness reduces vaccine efficacy or increases vaccine adverse events. However, as a precaution with moderate or severe acute illness, all vaccines should be delayed until the illness has improved. Mild illnesses (such as otitis media, upper respiratory infections, and diarrhea) are NOT contraindications to vaccination. Do not withhold vaccination if a person is taking antibiotics.

2. **Does the child have allergies to medications, food, a vaccine component, or latex?** *[all vaccines]*

   An anaphylactic reaction to latex is a contraindication to vaccines that contain latex as a component or as part of the packaging (e.g., vial stoppers, prefilled syringe plungers, prefilled syringe caps). If a person has anaphylaxis after eating gelatin, do not administer vaccines containing gelatin. A local reaction to a prior vaccine dose or vaccine component, including latex, is not a contraindication to a subsequent dose or vaccine containing that component. For information on vaccines supplied in vials or syringes containing latex, see www.cdc.gov/vaccines-pubs/pinkbook/downloads/appendices/B/latex-table.pdf; for an extensive list of vaccine components, see www.cdc.gov/vaccines/pubs/pinkbook/downloads/appendices/B/excipient-table-2.pdf. People with egg allergy of any severity can receive any recommended influenza vaccine (i.e., any IIV, RIV, or LAIV) that is otherwise appropriate for the patient's age and health status. For people with a history of severe allergic reaction to egg involving any symptom other than hives (e.g., angioedema, respiratory distress), or who required epinephrine or another emergency medical intervention, the vaccine should be administered in a medical setting, such as a clinic, health department, or physician office. Vaccine administration should be supervised by a healthcare provider who is able to recognize and manage severe allergic conditions.[5]

3. **Has the child had a serious reaction to a vaccine in the past?** *[all vaccines]*

   History of anaphylactic reaction (see question 2) to a previous dose of vaccine or vaccine component is a contraindication for subsequent doses. History of encephalopathy within 7 days following DTP/DTaP is a contraindication for further doses of pertussis-containing vaccine. There are other adverse events that might have occurred following vaccination that constitute contraindications or precautions to future doses. Under normal circumstances, vaccines are deferred when a precaution is present. However, situations may arise when the benefit outweighs the risk (e.g., during a community pertussis outbreak).

4. **Does the child have a long-term health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?** *[MMR, MMRV, LAIV, VAR]*

   A history of thrombocytopenia or thrombocytopenic purpura is a precaution to MMR and MMRV vaccines. The safety LAIV in children and teens with lung, heart, kidney, or metabolic disease (e.g., diabetes), or a blood disorder has not been established. These conditions, including asthma in children ages 5 years and older, should be considered precautions for the use of LAIV. Children with functional or anatomic asplenia, complement deficiency, cochlear implant, or CSF leak should not receive LAIV. Children on long-term aspirin therapy should not be given LAIV; instead, they should be given IIV. Aspirin use is a precaution to VAR.

5. **If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?** *[LAIV]*

   Children ages 2 through 4 years who have had a wheezing episode within the past 12 months should not be given LAIV. Instead, these children should be given IIV.

6. **If your child is a baby, have you ever been told that he or she has had intussusception?** *[Rotavirus]*

   Infants who have a history of intussusception (i.e., the telescoping of one portion of the intestine into another) should not be given rotavirus vaccine.

7. **Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problem?** *[DTaP, Td, Tdap, IIV, LAIV, MMRV]*

   DTaP and Tdap are contraindicated in children who have a history of encephalopathy within 7 days following DTP/DTaP. An unstable progressive neurologic problem is a precaution to the use of DTaP and Tdap. For children with stable neurologic disorders (including seizures) unrelated to vaccination, or for children with a family history of seizures, vaccinate as usual (exception: children with a personal or family [i.e., parent or sibling] history of seizures generally should not be vaccinated with MMRV; they should receive separate MMR and VAR vaccines). A history of Guillain-Barré syndrome (GBS) is a consideration with the following: 1) Td/Tdap: if GBS has occurred within 6 weeks of a tetanus-containing vaccine and decision is made to continue vaccination, give Tdap instead of Td if no history of prior Tdap; 2) Influenza vaccine (IIV or LAIV): if GBS has occurred within 6 weeks of a prior influenza vaccination, vaccinate with IIV if at high risk for severe influenza complications.

NOTE: For summary information on contraindications and precautions to vaccines, go to the ACIP's General Best Practice Guidelines for Immunization at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html

8. **Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?** *[LAIV, MMR, MMRV, RV, VAR]*

   Live virus vaccines (e.g., MMR, MMRV, VAR, RV, LAIV) are usually contraindicated in immunocompromised children. However, there are exceptions. For example, MMR is recommended for asymptomatic HIV-infected children who do not have evidence of severe immunosuppression. Likewise, VAR should be considered for HIV-infected children age 12 months through 8 years with age-specific CD4+ T-lymphocyte percentage at 15% or greater, or for children age 9 years or older with CD4+ T-lymphocyte counts of greater than or equal to 200 cell/μL. Immunosuppressed children should not receive LAIV. Infants who have been diagnosed with severe combined immunodeficiency (SCID) should not be given a live virus vaccine, including RV. Other forms of immunosuppression are a precaution, not a contraindication, to RV. For details, consult ACIP recommendations (see references in **Notes** above).

9. **Does the child have a parent, brother, or sister with an immune system problem?** *[MMR, MMRV, VAR]*

   MMR, VAR, and MMRV vaccines should not be given to a child or teen with a family history of congenital or hereditary immunodeficiency in first-degree relatives (i.e., parents, siblings) unless the immune competence of the potential vaccine recipient has been clinically substantiated or verified by a laboratory.

10. **In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?** *[LAIV, MMR, MMRV, VAR]*

    Live virus vaccines (e.g., LAIV, MMR, MMRV, VAR) should be postponed until after chemotherapy or long-term high-dose steroid therapy has ended. For details and length of time to postpone, consult the ACIP statement. Some immune mediator and immune modulator drugs (especially the antitumor-necrosis factor agents adalimumab, infliximab, and etanercept) may be immunosuppressive. A comprehensive list of immunosuppressive immune modulators is available in CDC Health Information for International Travel (the "Yellow Book") available at wwwnc.cdc.gov/travel/yellowbook/2018/advising-travelers-with-specific-needs/immunocompromised-travelers. The use of live vaccines should be avoided in persons taking these drugs. To find specific vaccination schedules for stem cell transplant (bone marrow transplant) patients, see General Best Practice Guidelines for Immunization (referenced in **Notes** above). LAIV, when recommended, can be given only to healthy non-pregnant people ages 2 through 49 years.

11. **In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?** *[MMR, MMRV, VAR]*

    Certain live virus vaccines (e.g., MMR, MMRV, VAR) may need to be deferred, depending on several variables. Consult the most current ACIP recommendations (referenced in **Notes** above) for the most current information on intervals between antiviral drugs, immune globulin or blood product administration and live virus vaccines.

12. **Is the child/teen pregnant or is there a chance she could become pregnant during the next month?** *[HPV, IPV, LAIV, MMR, MMRV, VAR]*

    Live virus vaccines (e.g., MMR, MMRV, VAR, LAIV) are contraindicated one month before and during pregnancy because of the theoretical risk of virus transmission to the fetus. Sexually active young women who receive a live virus vaccine should be instructed to practice careful contraception for one month following receipt of the vaccine. On theoretical grounds, IPV should not be given during pregnancy; however, it may be given if risk of exposure is imminent (e.g., travel to endemic areas) and immediate protection is needed. IIV and Tdap are both recommended during pregnancy. HPV vaccine is not recommended during pregnancy.

13. **Has the child received vaccinations in the past 4 weeks?** *[LAIV, MMR, MMRV, VAR, yellow fever]*

    Children who were given either LAIV or an injectable live virus vaccine (e.g., MMR, MMRV, VAR, yellow fever) should wait 28 days before receiving another vaccination of this type. Inactivated vaccines may be given at the same time or at any spacing interval.

VACCINE ABBREVIATIONS

LAIV = Live attenuated influenza vaccine
HPV = Human papillomavirus vaccine
IIV = Inactivated influenza vaccine
IPV = Inactivated poliovirus vaccine
MMR = Measles, mumps, and rubella vaccine
MMRV = MMR+VAR vaccine
RIV = Recombinant influenza vaccine
RV = Rotavirus vaccine
Td/Tdap = Tetanus, diphtheria, (acellular pertussis) vaccine
VAR = Varicella vaccine

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State of Illinois
Certificate of Child Health Examination

Student's Name			Birth Date	Sex	Race/Ethnicity	School /Grade Level/ID#
Last	First	Middle	Month/Day/Year			
Address Street	City	Zip Code	Parent/Guardian	Telephone # Home		Work

IMMUNIZATIONS: To be completed by health care provider. The mo/da/yr for *every* dose administered is required. If a specific vaccine is medically contraindicated, a separate written statement must be attached by the health care provider responsible for completing the health examination explaining the medical reason for the contraindication.

REQUIRED Vaccine / Dose	DOSE 1 MO DA YR	DOSE 2 MO DA YR	DOSE 3 MO DA YR	DOSE 4 MO DA YR	DOSE 5 MO DA YR	DOSE 6 MO DA YR
DTP or DTaP						
Tdap, Td or Pediatric DT (Check specific type)	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT	☐Tdap ☐Td ☐DT
Polio (Check specific type)	☐				V	☐ IPV ☐ OPV
Hib Haemophilus influenza type b						
Pneumococcal Conjugate						
Hepatitis B						
MMR Measles Mumps, Rubella						lid dose
Varicella (Chickenpox)						
Meningococcal conjugate (MCV4)						
RECOMMENDED, BUT N						
Hepatitis A						
HPV						
Influenza						
Other: Specify Immunization Administered						

This and the next page are if your child needs or may need a physical completed for school / sports within the next 12 months. Please complete the highlighted section on the next page, so that we have this on file. If a physical is needed, we can call them down from class to complete.

Thanks!

Health care provider (M istory must sign below.
If adding dates to the abov

Signature

Signature **Title** **Date**

ALTERNATIVE PROOF OF IMMUNITY

1. Clinical diagnosis (measles, mumps, hepatitis B) is allowed when verified by physician and supported with lab confirmation. Attach copy of lab result.
***MEASLES (Rubeola)** MO DA YR ****MUMPS** MO DA YR **HEPATITIS B** MO DA YR **VARICELLA** MO DA YR

2. History of varicella (chickenpox) disease is acceptable if verified by health care provider, school health professional or health official.
Person signing below verifies that the parent/guardian's description of varicella disease history is indicative of past infection and is accepting such history as documentation of disease.

Date of Disease **Signature** **Title**

3. Laboratory Evidence of Immunity (check one) ☐**Measles*** ☐**Mumps**** ☐**Rubella** ☐**Varicella** **Attach copy of lab result.**

*All measles cases diagnosed on or after July 1, 2002, must be confirmed by laboratory evidence.
**All mumps cases diagnosed on or after July 1, 2013, must be confirmed by laboratory evidence.

Completion of Alternatives 1 or 3 MUST be accompanied by Labs & Physician Signature: _____
Physician Statements of Immunity MUST be submitted to IDPH for review.

Certificates of Religious Exemption to Immunizations or Physician Medical Statements of Medical Contraindication Are Reviewed and *Maintained* by the School Authority.

Last	First	Middle	Birth Date (Month/Day/ Year)	Sex	School	Grade Level/ ID

HEALTH HISTORY — TO BE COMPLETED AND SIGNED BY PARENT/GUARDIAN AND VERIFIED BY HEALTH CARE PROVIDER

ALLERGIES (Food, drug, insect, other)	Yes / No	List:

Diagnosis of asthma?	Yes	No	
Child wakes during night coughing?	Yes	No	
Birth defects?	Yes	No	
Developmental delay?	Yes	No	
Blood disorders? Hemophilia, Sickle Cell, Other? Explain.	Yes	No	
Diabetes?	Yes	No	
Head injury/Concussion/Passed out?	Yes	No	
Seizures? What are they like?	Yes	No	
Heart problem/Shortness of breath?	Yes	No	
Heart murmur/High blood pressure?	Yes	No	
Dizziness or chest pain with exercise?	Yes	No	

Eye/Vision problems? _____ Glasses ☐ Contacts ☐ Last exam by eye doctor ____
Other concerns? (crossed eye, drooping lids, squinting, difficulty reading)

Ear/Hearing problems?	Yes	No	
Bone/Joint problem/injury/scoliosis?	Yes	No	

MEDICATION (Prescribed or taken on a regular basis.)	Yes / No	List:

Loss of function of one of paired organs? (eye/ear/kidney/testicle)	Yes	No	
Hospitalizations? When? What for?	Yes	No	
Surgery? (List all.) When? What for?	Yes	No	
Serious injury or illness?	Yes	No	
TB skin test positive (past/present)?	Yes*	No	*If yes, refer to local health department.
TB disease (past or present)?	Yes*	No	
Tobacco use (type, frequency)?	Yes	No	
Alcohol/Drug use?	Yes	No	
Family history of sudden death before age 50? (Cause?)	Yes	No	

Dental ☐ Braces ☐ Bridge ☐ Plate Other

Information may be shared with appropriate personnel for health and educational purposes.
Parent/Guardian Signature **Date**

PHYSICAL EXAMINATION REQUIREMENTS **Entire section below to be completed by MD/DO/APN/PA**
HEAD CIRCUMFERENCE if < 2-3 years old **HEIGHT** **WEIGHT** **BMI** **BMI PERCENTILE** **B/P**

DIABETES SCREENING (NOT REQUIRED FOR DAY CARE) **BMI>85% age/sex** Yes☐ No☐ And any two of the following: **Family History** Yes☐ No☐
Ethnic Minority Yes☐ No☐ **Signs of Insulin Resistance** (hypertension, dyslipidemia, polycystic ovarian syndrome, acanthosis nigricans) Yes☐ No☐ **At Risk** Yes☐ No☐

LEAD RISK QUESTIONNAIRE: Required for children age 6 months through 6 years enrolled in licensed or public school operated day care, preschool, nursery school and/or kindergarten. (Blood test required if resides in Chicago or high risk zip code.)
Questionnaire Administered? Yes☐ No■ **Blood Test Indicated?** Yes■ No☐ **Blood Test Date** **Result**

TB SKIN OR BLOOD TEST Recommended only for children in high-risk groups including children immunosuppressed due to HIV infection or other conditions, frequent travel to or born in high prevalence countries or those exposed to adults in high-risk categories. See CDC guidelines. http://www.cdc.gov/tb/publications/factsheets/testing/TB_testing.htm
No test needed ☐ **Test performed** ☐ **Skin Test: Date Read** **Result: Positive** ☐ **Negative** ☐ **mm**
Blood Test: Date Reported **Result: Positive** ☐ **Negative** ☐ **Value**

LAB TESTS (Recommended)	Date	Results		Date	Results
Hemoglobin or Hematocrit			Sickle Cell (when indicated)		
Urinalysis			Developmental Screening Tool		

SYSTEM REVIEW	Normal	Comments/Follow-up/Needs		Normal	Comments/Follow-up/Needs
Skin			Endocrine		
Ears		Screening Result:	Gastrointestinal		
Eyes		Screening Result:	Genito-Urinary		LMP
Nose			Neurological		
Throat			Musculoskeletal		
Mouth/Dental			Spinal Exam		
Cardiovascular/HTN			Nutritional status		
Respiratory		■ Diagnosis of Asthma	Mental Health		
Currently Prescribed Asthma Medication: ■ Quick-relief medication (e.g. Short Acting Beta Agonist) ☐ Controller medication (e.g. inhaled corticosteroid)			Other		

NEEDS/MODIFICATIONS required in the school setting
DIETARY Needs/Restrictions

SPECIAL INSTRUCTIONS/DEVICES e.g. safety glasses, glass eye, chest protector for arrhythmia, pacemaker, prosthetic device, dental bridge, false teeth, athletic support/cup

MENTAL HEALTH/OTHER Is there anything else the school should know about this student?
If you would like to discuss this student's health with school or school health personnel, check title: ☐ Nurse ☐ Teacher ☐ Counselor ☐ Principal

EMERGENCY ACTION needed while at school due to child's health condition (e.g., seizures, asthma, insect sting, food, peanut allergy, bleeding problem, diabetes, heart problem)?
Yes ☐ **No** ☐ If yes, please describe.

On the basis of the examination on this day, I approve this child's participation in (If No or Modified please attach explanation.)
PHYSICAL EDUCATION **Yes** ☐ **No** ☐ **Modified** ☐ **INTERSCHOLASTIC SPORTS** **Yes** ☐ **No** ☐ **Modified** ☐

Print Name (MD,DO, APN, PA) **Signature** **Date**
Address **Phone**

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UNITYPOINT CLINIC - METHODIST
PATIENT RIGHTS AND RESPONSIBILIITES

While you are a patient of UnityPoint Clinic - Methodist, we will do our best to protect and promote your personal rights in accordance with all relevant state and federal laws and the standards of the Joint Commission. For additional information about your rights, you may contact one of our Patient Advocates at (309) 671-8209.

ACCESS TO CARE.

YOU / YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. To be informed of your rights.
2. To receive care that respects your individual, cultural, spiritual and social values, regardless of race, ethnicity, color, creed, religion, nationality, age, gender, sexual orientation, gender identity or expression, language, marital status, socioeconomic status, status with regard to public assistance, disability, or any other classification protected by law.
3. To have your cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
4. Receiving a medical screening examination and stabilizing care, regardless of ability to pay.
5. To receive care, treatment, and services within the capability of the hospital or to be evaluated, referred and transferred to another facility only after you have received complete information and explanation concerning the needs for an alternative provider.
6. Receiving a consultation or second opinion from another physician as well as to change physicians or seek specialty care.
7. Ability to examine and receive a reasonable explanation of your medical bill regardless of source of payment.
8. To have a family member or representative of your choice and your own physician notified promptly of your admission to the hospital.
9. To receive communication in a manner consistent with your needs, including interpreters and assistive devices.

RESPECT / DIGNITY / CONFIDENTIALITY / SAFETY.

YOU / YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. To be treated with respect for property, personal space, and preservation of personal dignity.
2. To privacy, confidentiality, safety, and security for your person, clinical record, and protected health information.
3. To report safety concerns.
4. To an environment that preserves dignity, safety, and contributes to a positive self-image.
5. To be free from mental, physical, sexual, and verbal abuse, neglect, exploitation, corporal punishment, and all forms of abuse or harassment.
6. To be made aware of protective services. Specific information on protective agencies and procedures will be provided upon request.
7. To receive pastoral care and other spiritual services upon request to the extent possible.
8. To receive adequate information about the person(s) responsible for the delivery of your care, treatment, and services.
9. To be free from restraint and/or seclusion of any form unless needed for the purpose of protecting you or others from injury or with critical medical treatment. Restraints are used while preserving patient's rights, dignity, and wellbeing. Patients will not be restrained as a means of coercion, discipline, convenience, or retaliation by staff.

INVOLVEMENT IN CARE / INFORMED CONSENT / RESEARCH.

YOU / YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. Ability to access all information concerning your medical condition, treatment, prognosis and other treatment available and to choose among these alternatives.
2. To request a discussion of ethical issues relating to your care, including conflict resolution, resuscitation (being revived if you stop breathing) and life-sustaining treatment.
3. Ability to make informed decisions regarding your care. This right includes being informed of your health status and diagnosis, prognosis (possible outcome), proposed procedures (including risks involved), being involved in development / implementation / management of your plan of care and treatment, and being able to request and refuse treatment and to know what may happen if you don't have this treatment.
4. To be informed about the outcomes of care, treatment, and services that have been provided, including unanticipated outcomes.

5. To receive care to make you as comfortable as possible at all stages of life, including end-of-life care, and have your spiritual needs and those of your family met.
6. Ability to designate a health care decision-maker if incapable if understanding a proposed treatment or if unable to communicate your wishes regarding care.
7. To formulate, review, revise, and revoke advance directives and to have hospital staff and practitioners comply with these directives consistent with applicable law and to receive comfort and dignity at the end of life.
8. Ability to participate in approved research studies, after giving informed consent. Ability to refuse to participate in research studies without such refusal affecting care.
9. To provide consent for recording or filming made for purposes other than identification, diagnosis, and treatment; to request cessation of recording or filming at any time; and to rescind consent before the recording or film is used.
10. Receive appropriate pain management support.
11. Ability to access your medical record or ability to request a copy of your medical record within a reasonable time frame (within 30 days of your request).
12. To be informed of the rules and regulations applicable to your conduct as a patient.

COMPLAINT / GRIEVANCE PROCEDURE.

YOU / YOUR REPRESENTATIVE'S RIGHTS INCLUDE:

1. Ability to discuss any concerns / dissatisfaction with the care received, which cannot be resolved by available staff, without being subject to coercion, discrimination, reprisal, unreasonable interruption of care, by contacting a Patient Advocate at (309) 671-8209 or ask any staff member to contact them on your behalf.
2. To be informed of the initiation, review, and when possible, resolution of patient complaints concerning safety, treatment, or services. Contact the Patient Advocate at (309) 671-8209 or if you prefer, write your grievance and send to: Patient Advocate, c/o UnityPoint Health – Methodist | Proctor, 221 NE Glen Oak Ave., Peoria, IL 61636.
3. You have the right to file a complaint with the following agencies as well as or instead of utilizing the organization's grievance process: The Joint Commission at (800) 994-6610 (Office of Quality and Patient Safety, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181; email: patientsafetyreport@jointcommission.org); or the Illinois Department of Public Health hotline at (800) 252-4343 (535 W. Jefferson Street, Springfield, IL 62761).
4. If you have questions about your rights, please contact a Patient Advocate at (309) 671-8209.

COMMUNITY CARE PROGRAM:

You may be eligible for financial assistance under the terms and conditions UnityPoint – Methodist | Proctor offers to qualified patients. For more information, contact 1-888-343-4165.

VISITATION RIGHTS

In concert with patient centered care, UnityPoint Clinic has an open policy regarding patient visitation. Exceptions are as follows:

- ☐ If contraindicated by the patient's condition
- ☐ If the patient's physician requests a restriction
- ☐ If the patient requests a restriction
- ☐ For infection control reasons
- ☐ For minors
- ☐ If there are other clinically appropriate or reasonable restrictions such as:
  - disruptive behavior of a visitor
  - court order limiting or restraining contact
  - behavior presenting a direct risk to other patients or staff
  - the visitor's presence infringes on others' rights / safety
  - medically or therapeutically contraindicated
  - other clinical reason as determined by the clinic

The clinic will not deny visitation privileges on the basis of age, race, sex, color, gender identity, national origin, religion, sexual orientation, disability, or any other protected class in any manner prohibited by federal or state laws. As a patient*, you have the right to receive or restrict any visitors you designate, including, but not limited to, a spouse, a domestic partner (including a same sex domestic partner), another family member, clergy, and/or

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friend. The individual may or may not be the patient's surrogate decision maker or legally authorized representative. You may modify your visitation request at any time by communicating your wishes to the staff. If you have any questions or concerns about visitation, please contact a Patient Advocate at (309) 671-8209.

PATIENT RESPONSIBILITIES:

THE PATIENT AND / OR, WHEN APPROPRIATE, FAMILY IS RESPONSIBLE FOR:

1. Provide, to the best of your ability, accurate and complete information about your pain; medical history; including past illnesses, hospitalizations, medications, sensitivities or allergies to drugs and other agents; and other matters related to your health.
2. Inform appropriate healthcare professionals of any change in your condition or reaction to your treatment.
3. Ask questions when you do not understand what you have been told about your care or what is expected of you.
4. Express any concerns you may have about your ability to follow and comply with the proposed plan of care or course of treatment.
5. Accept the consequences for refusing treatment or not following healthcare providers' instructions.
6. Show consideration for other patients / visitors and respect UnityPoint Clinic staff and property. This includes controlling noise and observing the no-smoking policy.
7. Follow UnityPoint Clinic rules and regulations affecting patient care, conduct, safety, and visiting.
8. Inform healthcare providers of any Advance Directives that are in effect and provide copies of such documents.
9. Notify healthcare providers as soon as possible if your rights have been or may have been violated.
10. Provide insurance information for processing billing.
11. Ensure that financial obligations are fulfilled as promptly as possible.

***If the patient is a minor (not of legal age) or unable to give consent, these rights and responsibilities apply to the patient's parent, legal guardian, or representative.**

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Notice of Privacy Practices

INTRODUCTION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.We are required by law to maintain the privacy of your health information and to give you our Notice of Privacy Practices (this "Notice") that describes our privacy practices, legal duties and your rights concerning your medical information. Your health information includes your individually identifiable medical, insurance, demographic and medical payment information. For example, it includes information about your diagnosis, medications, insurance status, medical claims history, address, and policy or social security number.

WHO WILL FOLLOW THIS NOTICE

THE UNITYPOINT HEALTH AFFILIATED COVERED ENTITY.

This Notice describes the privacy practices of the organizations listed in Appendix A ("Affiliates"), which form the UnityPoint Health Affiliated Covered Entity ("UnityPoint Health ACE") including hospitals, clinics and other health care providers that the organizations operate, as well as any health care facility or physician practice now or in the future controlled by or under common control by UnityPoint Health. The organizations are part of the UnityPoint Health Affiliated Covered Entity ("UnityPoint Health ACE.")MEDICAL STAFF. This Notice also describes the privacy practices of the physicians, nurse practitioners and other health care professional on our medical staffs (collectively "Practitioners") and other health care providers that provide health care services in our hospitals, clinics and other sites. Legally this is called an "organized health care arrangement" or "OHCA" between the UnityPoint Health ACE and eligible providers on its Medical Staff. Because the UnityPoint Health ACE is a clinically-integrated care setting, our patients receive care from UnityPoint Health ACE staff and from independent practitioners on the Medical Staff. The UnityPoint Health ACE and its Medical Staff must be able to share your health information freely for treatment, payment and health care operations as described in this Notice. Because of this, the UnityPoint Health ACE and all eligible providers on the UnityPoint Health ACE's Medical Staff have entered into the OHCA under which the UnityPoint Health ACE and the eligible providers will:

- Use this Notice as a joint notice of privacy practices for all inpatient and outpatient visits and follow all information practices described in this notice
- Obtain a single signed acknowledgment of receipt
- Share health information from inpatient and outpatient hospital visits with eligible providers so that they can help the UnityPoint Health ACE with its health care operations

Accordingly, this Notice will be followed by (1) our workforce members and (2) the independent physicians and other Practitioners who are not employees, agents, servants, partners or joint venturers of UnityPoint Health or its Affiliates. All Practitioners are solely responsible for their judgment and conduct in treating or providing professional services to patients and for their compliance with state and federal laws. Nothing in this Notice is meant to imply or create an employment relationship between any independent physician or other Practitioner and us. We use a joint Notice of Privacy Practices and a joint Acknowledgement Form with independent physicians and other practitioners to reduce paperwork and make it easier to share information to improve your care. This Notice does not change or limit any consents for treatment or procedures the patient may sign during the time the patient receives care from any of us.

The OHCA does not cover the information practices of practitioners in their private offices or at other practice locations

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

The following are the types of uses and disclosures we may make of your health information without your permission. Where state or federal law restricts one of the described uses or disclosures, we follow the requirements of such state or federal law. These are general descriptions only. They do not cover every example of disclosure within a category.

TREATMENT. We will use and disclose your health information for treatment. For example, we will share health information about you with nurses, physicians, students and others who are involved in your care at a UnityPoint Health Affiliate. Our Affiliates enter and can view your health information in our electronic medical record system. We will also disclose your health information to your physician and other practitioners, providers and health care facilities that provide care for you at their sites, rather than at our sites, for their use in treating you in the future. For example, if you are transferred from one of our hospitals to a nursing facility, we will send health information about you to the nursing facility.

PAYMENT. We will use and disclose your health information for payment purposes. For example, we will use your health information to prepare your bill and we will send health information to your insurance company with your bill. We may also disclose health information about you to other health care providers, health plans and health care clearinghouses for their payment purposes. For example, if you are brought in by ambulance, the information collected will be given to the ambulance provider for its billing purposes. If state law requires, we will obtain your permission prior to disclosing to other providers or health insurance companies for payment purposes.

HEALTH CARE OPERATIONS. We may use or disclose your health information for our health care operations. For example, medical staff members or members of our workforce may review your health information to evaluate the treatment and services provided, and the performance of our staff in caring for you. In some cases, we will furnish other qualified parties with your health information for their health care operations. The ambulance company, for example, may also want information on your condition to help them know whether they have done an effective job of providing care. If state law requires, we will obtain your permission prior to disclosing your health information to other providers or health insurance companies for their health care operations.

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APPOINTMENT REMINDERS. We may contact you as a reminder that you have an appointment for treatment or medical services.

TREATMENT ALTERNATIVES. We may contact you to provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.

FUNDRAISING. We may contact you by writing, phone or other means as part of a fundraising effort for the purpose of raising money for one or more of our organizations listed in Appendix A, and you will have the right to opt out of receiving such communications with each solicitation. Please note that we will promptly process your request to be removed from our fundraising list, and we will honor your request unless we have already sent a communication prior to receiving notice of your election to opt out. We may also use and we may disclose to a business associate or to a foundation related to the UnityPoint Health ACE or one of its Affiliates certain health information about you, such as your name, address, phone number, e-mail information, dates you received treatment or services, treating physician, outcome information, and department of service (for example, cardiology or orthopedics), so that we or they may contact you to raise money on our behalf. The money raised will be used to expand and improve the services and programs we provide the community. You are free to opt out of fundraising solicitation, and your decision will have no impact on your treatment or payment for services by any of the entities covered by this Notice.

FACILITY DIRECTORY. While you are an inpatient at any UnityPoint Health hospital, your name, location in the facility, general condition (e.g., fair, serious, etc.) and religious affiliation may be included in a facility directory. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. You have the right to request that your name not be included in the directory. We will not include your information in the facility directory if you object or if we are prohibited by state or federal law.

FAMILY, FRIENDS OR OTHERS. We may disclose your location or general condition to a family member, your personal representative or another person identified by you. If any of these individuals are involved in your care or payment for care, we may also disclose such health information as is directly relevant to their involvement. We will only release this information if you agree, are given the opportunity to object and do not, or if in our professional judgment, it would be in your best interest to allow the person to receive the information or act on your behalf. For example, we may allow a family member to pick up your prescriptions, medical supplies or X-rays. In addition, if you are unavailable, incapacitated or in an emergency situation, we may disclose
Illinois limited information to these persons if we determine in our professional judgment that we believe it is in your best interest. We may also disclose your information to an entity assisting in disaster relief efforts so that your family or individual responsible for your care may be notified of your location and condition.

REQUIRED BY LAW. We will use and disclose your information as required by federal, state or local law, such as to report child or dependent adult abuse.

PUBLIC HEALTH ACTIVITIES. We may disclose health information about you for public health activities. These activities may include disclosures:

- to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury or disability
- to appropriate authorities authorized to receive reports of child abuse and neglect
- to FDA-regulated entities for purposes of monitoring or reporting the quality, safety or effectiveness of FDA-regulated products
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition• with parent or guardian permission, to send proof of required immunization(s) to a school

ABUSE, NEGLECT OR DOMESTIC VIOLENCE. We may notify the appropriate government authority if we believe an individual has been the victim of abuse, neglect or domestic violence. Unless such disclosure is required by law (for example, to report a particular type of injury), we will only make this disclosure if you agree or in other limited circumstances when such disclosure is authorized by law.

HEALTH OVERSIGHT ACTIVITIES. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

LEGAL PROCEEDINGS. If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if reasonable efforts have been made to notify you of the request or to obtain an order from the court protecting the information requested.

LAW ENFORCEMENT. We may release certain health information to law enforcement authorities for law enforcement purposes, such as

- as required by law, including reporting certain wounds and physical injuries
- in response to a court order, subpoena, warrant, summons or similar process
- to identify or locate a suspect, fugitive, material witness or missing person
- about the victim of a crime if we obtain the individual's agreement or, under certain limited circumstances, if we are unable to obtain the individual's agreement
- to alert authorities of a death we believe may be the result of criminal conduct
- information we believe is evidence of criminal conduct occurring on our premises
- in emergency circumstances to report a crime; the location of the crime or victims or the identity, description or location of the person who committed the crime.

We must comply with federal and state laws in making such disclosures for law enforcement purposes.

DECEASED INDIVIDUALS. Following your death, we may disclose health information to a coroner or to a medical examiner as necessary for them to carry out their duties and to funeral directors as authorized by law. In addition, following your death, we may disclose health information to a personal representative (for example, the executor of your estate), and unless you have expressed a contrary preference, we may also release your health information to a family member or other person who acted as a personal representative or was involved in your care or payment for care before your death, if the health information is relevant to such person's involvement in your care or payment for care. We are required to apply safeguards to protect your health information for 50 years following your death.

ORGAN, EYE OR TISSUE DONATION. We may release health information to organ, eye or tissue procurement, transplantation or banking organizations or entities as necessary to facilitate organ, eye or tissue donation and transplantation.

RESEARCH. Under certain circumstances, we may use or disclose your health information for research, subject to certain safeguards. For example, we may disclose information to researchers when their research has been approved by a special committee that has reviewed the research proposal and established protocols to ensure the privacy of your health information. We may disclose health information about you to people preparing to conduct a research project, but the information will stay on site.

THREATS TO HEALTH OR SAFETY. Under certain circumstances, we may use or disclose your health information to prevent a serious and imminent threat to health and safety if we, in good faith, believe the use or disclosure is necessary to prevent or lessen the threat and the disclosure is to a person reasonably able to prevent or lessen the threat (including the target) or is necessary for law enforcement authorities to identify or apprehend an individual involved in a crime.

SPECIALIZED GOVERNMENT FUNCTIONS. We may use and disclose your health information for national security and intelligence activities authorized by law or for protective services of the President. If you are a military member, we may disclose to military authorities under certain circumstances. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose to the institution, its agents or the law enforcement official your health information necessary for your health and the health and safety of other individuals.

WORKERS' COMPENSATION. We may release health information about you as authorized by law for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

INCIDENTAL USES AND DISCLOSURES. There are certain incidental uses or disclosures of your information that occur while we are providing service to you or conducting our business. For example, after surgery the nurse or doctor may need to use your name to identify family members that may be waiting for you in a waiting area. Other individuals waiting in the same area may hear your name called. We will make reasonable efforts to limit these incidental uses and disclosures.

HEALTH INFORMATION EXCHANGE. We participate in one or more electronic health information exchanges, which permits us to exchange health information about you with other participating providers (for example, doctors and hospitals) and their business associates. For example, we may permit a physician providing care to you to access our records in order to have current information with which to treat you. In all cases, the requesting provider must verify that they have or have had a treatment relationship with you, and, if required by law, we will ask the provider to obtain your consent before accessing your health information through the health information exchange. Participation in a health information exchange also lets us access health information from other participating providers and health plans for our treatment, as well as for payment and health care operations purposes when allowed by law or with your consent. We may in the future allow other parties, for example, public health departments, that participate in the health information exchange, to access your protected health information for their limited uses in compliance with federal and state privacy laws, such as to conduct public health activities.

IOWA HEALTH INFORMATION NETWORK (IHIN). For patients who receive care with us, the UnityPoint Health ACE may participate in the Iowa Health Information Network ("IHIN"), which is the state health information exchange. Iowa law provides that health information, including mental health treatment records and HIV/AIDS testing records, may be shared between providers through the IHIN for treatment, payment or health care operations purposes without patient consent. If you do not want to have your health information shared with providers through the IHIN, you may contact the Iowa Department of Public Health or any of our UnityPoint Health ACE privacy officers to obtain information on how you can opt out of the IHIN. Please note that the records of all of our patients will be accessible through IHIN not just the records of patients treated at Iowa facilities or Iowa residents. The website for the IHIN Opt Out at the time of the printing of this Notice is http://www.iowaehealth.org/patient/privacy-security/opt-out/, or you may call Iowa e-Health at 866-924-4636.

CENTRAL ILLINOIS HEALTH INFORMATION EXCHANGE (CIHIE). For patients who receive care with us, the UnityPoint Health ACE may participate in the Central Illinois Health Information Exchange ("CIHIE"), which is the state health information exchange. Illinois law provides that health information, including mental health treatment records and HIV/AIDS testing records, may be shared between providers through the CIHIE for treatment, payment or health care operations purposes without patient consent. For more information about the sharing of patient information through CIHIE, you may contact us at 309-672-4488 or review information on the CIHIE website at www.cihie.org. Please note that records of all of our patients will be accessible through CIHIE, not just the records of patients treated at Illinois facilities or Illinois residents. If you do not wish to have your records shared through CIHIE, you may contact any of our UnityPoint Health ACE privacy officers to opt out of this sharing.

BUSINESS ASSOCIATES. Some of the activities described above are performed through contracts with outside vendors called business associates. We will disclose your health information to our business associates and allow them to create, use and disclose your health information to perform their services for us. For example, we may disclose your health information to an outside billing company who assists us in billing insurance companies. We require business associates to appropriately safeguard the privacy of your information.

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ORGANIZED HEALTH CARE ARRANGEMENT. UnityPoint Health participates in multiple arrangements called "Organized Health Care Arrangements" or "OHCAs." For example, we offer clinically integrated care settings where patients receive care from Affiliates in the UnityPoint Health ACE and from independent doctors and other practitioners who provide care to patients at facilities in the UnityPoint Health ACE (collectively called "practitioners"). The Affiliates and these practitioners need to share health information freely to provide care to patients and to conduct Affiliates' health care operations. Therefore, the Affiliates and the practitioners have agreed to follow uniform information practices when using or disclosing health information related to inpatient or outpatient hospital services. This arrangement is called an "Organized Health Care Arrangement" and only covers information practices for services rendered through the Affiliates. It does not cover the information practices of the practitioners in their offices or at other care settings. We also participate in an Organized Health Care Arrangement with providers participating in UnityPoint Health's Accountable Care Organization ("ACO"). We share information with providers in the ACO to carry out the health care operations of the ACO, which may include, for example, information regarding a physician's compliance with ACO protocols in the physician's treatment of you. Participating in the described ACOs does not alter the independent status of the Affiliates and the practitioners or ACO providers or make UnityPoint Health jointly responsible for the clinical services provided by them. The Affiliate(s) are not responsible for (1) the negligence (or mistakes) of the independent practitioners providing care at the Affiliate(s) or as part of the ACO or (2) any violations of your privacy rights by the independent practitioners.

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION. There are many uses and disclosures we will make only with your written authorization. These include:

- Uses and Disclosures Not Described Above. We will obtain your authorization for uses and disclosures of your health information that are not described in the Notice above.
- Psychotherapy Note. These are notes made by a mental health professional documenting conversations during private counseling sessions or in joint or group therapy. Many uses or disclosures of psychotherapy notes require your authorization.
- Marketing. We will not use or disclose your protected health information for marketing purposes without your authorization. Moreover, if we will receive any financial remuneration from a third party in connection with marketing, we will tell you that in the authorization form.
- Sale. We will not sell your protected health information to third parties without your authorization. Any such authorization will state that we will receive remuneration in the transaction.

If you provide authorization for the disclosure of your health information, you may revoke it at any time by giving us notice in accordance with our authorization policy and the instructions in our authorization form. Your revocation will not be effective for uses and disclosures made in reliance on your prior authorization.

YOUR RIGHTS

ACCESS TO HEALTH INFORMATION. You may inspect and copy much of the health information we maintain about you, with some exceptions. If we maintain the information electronically and you ask for an electronic copy, we will provide the information to you in the form and format you requested, assuming it is readily producible. If we cannot readily produce the record in the form and format you request, we will produce it another readable electronic form we agree to. We may charge a cost-based fee for producing copies or, if you request one, a summary. If you direct us to transmit your health information to another person, we will do so, provided your signed, written direction clearly designates the recipient and location for delivery. We may charge a fee for the costs of copying, mailing, and other supplies or work associated with your request. We will respond to your requests to exercise any of the above rights on a timely basis in accordance with our policies and as required by law.

REQUEST FOR RESTRICTIONS. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care or payment for your care. We are not required to agree to your request, with one exception explained in the next paragraph, but we will let you know whether we have agreed to your request.

We are required to agree to your request that we not disclose certain health information to your health plan for payment or health care operations purposes if (1) you pay out-of-pocket in full for all expenses related to that service either at the time of service or within timeframes specified by our written policies and (2) the disclosure is not otherwise required by law. Such a restriction will only apply to records that relate solely to the service for which you have paid in full. If we later receive an authorization from you dated after the date of your requested restriction which authorizes us to disclose all of your records to your health plan, we will assume you have withdrawn your request for restriction.

Several different covered entities listed at the start of this Notice use this Notice, including the entities listed in Attachment A that are a single covered entity known as the UnityPoint Health Affiliated Covered Entity (or UnityPoint Health ACE"), as well as physicians and other health care practitioners with permission to provide services at our sites who are independent of any UnityPoint Health Affiliate. You must make a separate request to each covered entity from whom you will receive services that are involved in your request for any type of restriction. Contact the UnityPoint Health ACE or Affiliate Privacy Officer at the contact information listed below if you have questions regarding which providers will be involved in your care.

AMENDMENT. You may request that we amend certain health information that we keep in your records if you believe that it is incorrect or incomplete. We may require you to give a reason to support your request. We are not required to make all requested amendments, but will give each request careful consideration. If we deny your request, we will provide you with a written explanation of the reasons and your rights.

ACCOUNTING. You have the right to receive a list of certain disclosures of your health information made by us or our business associates. You must state a time period for your request, which may not be longer than six years. The first list in any 12-month period will be provided to you for free; you may be charged a fee for each subsequent list you request within the same 12-month period. Your right to an accounting of disclosures does not include disclosures for treatment, payment or health care operations and certain other types of

disclosures, for example, as part of a facility directory or disclosure in accordance with your authorization. Requests must be in writing. You may contact the Privacy Officer to obtain a form to request an accounting of disclosures.

CONFIDENTIAL COMMUNICATIONS. You have the right to request that we communicate with you about your health information in a different way or at a different place. We will agree to your request if it is reasonable and specifies the alternate means or location to contact you.

NOTICE IN THE CASE OF BREACH. You have the right to receive notice of an access, acquisition, use or disclosure of your health information that is not permitted by HIPAA, if such access, acquisition, use or disclosure compromises the security or privacy of your PHI (we refer to this as a breach). We will provide such notice to you without unreasonable delay but in no case later than 60 days after we discover the breach.

HOW TO EXERCISE THESE RIGHTS. All requests to exercise these rights must be in writing. We will follow written policies to handle requests and notify you of our decision or actions and your rights. For more information or to obtain request forms, contact the Privacy Officer (see "Contact Information").

COMPLAINTS. If you have concerns about any of our privacy practices or believe that your privacy rights have been violated, you may file a complaint with the UnityPoint Health ACE using the contact information at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. You will not be penalized or retaliated against for filing a complaint.

WHO WILL FOLLOW THESE PRIVACY PRACTICES?

The health care organizations that are a part of UnityPoint Health have collectively formed an Affiliated Covered Entity or "ACE" under the HIPAA regulations for purposes of HIPAA compliance. A full list of organizations in the UnityPoint Health ACE, called "Affiliates" are listed in Appendix A to this Notice. Our rules to protect your privacy will be followed by all workforce members of the site where you are being treated, as well as physicians and other health care practitioners with permission to provide services at our sites who are independent of any UnityPoint Health Affiliate (together called "the UnityPoint Health ACE" in this Notice).

WHAT HEALTH INFORMATION IS COVERED UNDER THIS NOTICE?

This Notice covers health information at the UnityPoint Health ACE that may be written (such as a hard copy medical record file), spoken (such as physicians discussing treatment options), or electronic (such as billing records kept on a computer).

HOW CAN WE USE YOUR HEALTH INFORMATION?

The law allows the UnityPoint Health ACE to use or share your health information for routine activities without requiring your permission, such as:

- For treatment
- To run the hospital or physician group
- For payment
- For appointment reminders and communications

The law also allows the UnityPoint Health ACE to use and share Health information without your permission for other limited reasons, including:

- Public health activities
- Some research activities
- Health and safety reason
- Organ and tissue donation requests
- Workers' compensation requests
- Law enforcement requests
- Some fundraising activities
- Uses and sharing permitted or required by law

WHAT ACTIVITIES REQUIRE YOUR WRITTEN PERMISSION?

If the UnityPoint Health ACE needs to use or disclose your health information for other purposes not described in this frequently asked questions guide or the attached full Notice of Privacy Practices, we must ask for your written authorization.

WHAT ACTIVITIES DO YOU HAVE A RIGHT TO OBJECT TO?

In many circumstances, you may have the right to object before we do the following:

- Share information with your family members, friends or others involved in your care
- List your name, room number and condition in a directory available to hospital visitors, as well as list your religion in a directory available to clergy members.

WHAT ARE MY PRIVACY RIGHTS AS A PATIENT?

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You have the right to…

- Get a copy of your medical and billing records. If we maintain your records electronically, we will provide you with an electronic copy of your records when you request one.
- Ask us to change your medical and billing records if you think there is a mistake.
- Request a preferred method of contact (for example, having calls go to your cell phone rather than to your home or work).
- Get a list of certain health information shared for reasons other than treatment, billing or our health care operations with other persons or organizations.
- Receive a paper copy of our Notice of Privacy Practices. This is your copy of the Notice. If you would like an additional copy, you may request one at any UnityPoint Health Affiliate registration desk.
- Ask us to limit the information we share. (Note that we may not be able to grant requests beyond what the law requires.)
- Request that we not share your health information with your health plan for payment or health care operations purposes, if you pay out-of-pocket in full for all expenses related to that service as specified by our policies and the disclosure is not otherwise required by law.
- Complain in writing to us if you believe your privacy rights have been violated.

ABOUT THIS NOTICE

We are required to follow the terms of the Notice currently in effect. We reserve the right to change our practices and the terms of this Notice and to make the new practices and notice provisions effective for all health information that we maintain. Before we make such changes effective, we will make available the revised Notice by posting it in physical locations where we deliver care, where copies will also be available. The revised Notice will also be posted on our website at www.unitypoint.org. You are entitled to receive this Notice in writing at any time. For a written copy, please contact the Privacy Officer (see “Contact Information”).

EFFECTIVE DATE OF NOTICE: October 1, 2017

APPENDIX A:

LIST OF PROVIDERS COVERED UNDER THIS NOTICE OF PRIVACY PRACTICES

ALLEN HEALTH SYSTEMS, INC.
Allen Memorial Hospital Corporation , d/b/a Allen Hospital
Allen Women’s Health Center
Allen Occupational Health Services
United Medical Park Clinic Pharmacy
Allen Clinic Pharmacy
Black Hawk-Grundy Mental Health Center, Inc

BUENA VISTA REGIONAL MEDICAL CENTER

CENTRAL IOWA HEALTH SYSTEM
Central Iowa Hospital Corporation, d/b/a UnityPoint Health – Des Moines
Iowa Lutheran Hospital
Iowa Methodist Medical Center
Blank Children’s Hospital
Methodist West Hospital
John Stoddard Cancer Center
Blank Health Providers

CHEROKEE REGIONAL MEDICAL CENTER

CLARKE COUNTY HOSPITAL

FINLEY TRI-STATES HEALTH GROUP, INC.
The Finley Hospital
The Dubuque Visiting Nurse Association

GREENE COUNTY MEDICAL CENTER

GRUNDY COUNTY MEMORIAL HOSPITAL

HUMBOLDT COUNTY MEMORIAL HOSPITAL

IOWA PHYSICIANS CLINIC MEDICAL FOUNDATION D/B/A UNITYPOINT CLINIC

IOWA HEALTH SYSTEM D/B/A UNITYPOINT HEALTH

LORING HOSPITAL

MARENGO MEMORIAL HOSPITAL D/B/A COMPASS MEMORIAL HEALTHCARE

MERITER HEALTH SERVICES, INC.
Meriter Hospital, Inc.
Meriter Enterprises, Inc. d/b/a Meriter Home Health
Meriter Enterprises, Inc. d/b/a Meriter Laboratory
Meriter Medical Group, Inc.

POCAHONTAS COMMUNITY HOSPITAL

ST. LUKE'S HEALTHCARE
St. Luke's Methodist Hospital
St. Luke's/Jones Regional Medical Center d/b/a Jones Regional Medical Center
Continuing Care Hospital at St. Luke's L.C.
Anamosa Area Ambulance Service
Medical Laboratories of Eastern Iowa, Inc.

ST. LUKE'S HEALTH SYSTEM, INC.
Northwest Iowa Hospital Corporation, d/b/a St. Luke's Regional Medical Center of Sioux City
St. Luke's Health Resources, d/b/a UnityPoint Clinic
Siouxland Pace, Inc.

STEWART MEMORIAL COMMUNITY HOSPITAL

STORY COUNTY MEDICAL CENTER

SUMNER COMMUNITY CLUB D/B/A COMMUNITY MEMORIAL HOSPITAL

TRINITY HEALTH SYSTEMS, INC.
Trinity Regional Medical Center
Trimark Physicians Group
North Central Iowa Mental Health Center, Inc. d/b/a Berryhill Center

TRINITY REGIONAL HEALTH SYSTEM
Trinity Medical Center
Robert Young Center Trinity Health Enterprises, Inc.
Unity HealthCare, d/b/a Trinity Muscatine

UNITYPOINT AT HOME INCLUDING D/B/A
Cass County Public Health
Grundy County Public Health
Paula J. Baber Hospice Home (IPU)
Taylor House (IPU)
UnityPoint Hospice

UNITYPOINT HEALTH METHODIST/PROCTOR
Methodist Health Services Corporation
Proctor Health Care Incorporated
The Methodist Medical Center of Illinois

APPENDIX B:

NONDISCRIMINATION/ACCESSIBILITY NOTICE

UnityPoint Health does not discriminate, exclude, or treat people differently on the basis of race, color, national origin, age, disability, or sex. We provide the following for free:

- Communication aids and services to people with disabilities, such as:

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    - Sign language interpreters
    - Written information in other formats
- Language services to people whose primary language is not English, such as:
    - Interpreters
    - Information written in other languages

A Patient Representative is available if you need these services. A Patient Representative is also available to help you file a grievance if you believe that we have failed to provide these services or discriminated on the basis of race, color, national origin, age, disability, or sex. To connect with a Patient Representative, contact the Privacy Officer (see “Contact Information”).

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019
1-800-537-7697 (TDD)
Complaint forms are available athttp://www.hhs.gov/ocr/office/file/index.html

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (309) 672-4831

Chinese注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (309) 672-4831 。

French ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement. Appelez le (309) 672-4831.

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (309) 672-4831.

Gujarati સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો (309) 672-4831.

Hindi ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। (309) 672-4831 पर कॉल करें।

Hmong LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (309) 672-4831.

Italian ATTENZIONE: In caso la lingua parlata sia l’italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (309) 672-4831.

Korean주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (309) 672-4831 번으로 전화해 주십시오.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (309) 672-4831.

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (309) 672-4831.

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (309) 672-4831.

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (309) 672-4831.

Urdu بردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں۔ (309) 672-4831.

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (309) 672-4831.

CONTACT INFORMATION

If you have questions about this Notice, please contact:

Attention: Privacy Officer
221 NE Glen Oak Avenue
Peoria, IL 61636
(309) 672-4831

You may also contact the Privacy Officer for UnityPoint Health by sending written communications to: Privacy Officer, UnityPoint Health, 1776 West Lakes Parkway, Suite 400, West Des Moines, IA 50266 or calling (515) 241-4652.

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