Dear Parent,

Norwegian American Hospital and your school have partnered to help serve your child(ren). We are not here to take the place of your primary care provider, but understand that sometimes getting your child(ren) to the doctor can be difficult. We provide services at the school such as lead and hemoglobin testing, hearing and vision screening, physical exams and immunizations. Our services are provided AT **NO COST** to you and your family! This letter, as well as the Notice of Privacy Practices is for you to keep for reference, but we do need the following forms to be completed and returned to your school:

1. Norwegian American Hospital Pediatric Care-A-Van Consent & Registration Form: This form allows your child(ren) to be seen by the Pediatric Care-A-Van; please make sure form is completed and signed.
2. CPS Consent and Release of Liability: This form allows your school to communicate with Norwegian American Hospital about your child's health.
3. TB Risk Assessment: This form allows us to recognize children who are at risk for Tuberculosis – an infection in the lungs (it is a required part of the school physical).
4. Photo/Video Release Form: This form is not required, but is strongly encouraged. It allows us to highlight what we do so that we can continue to provide services at no cost.

By filling out these forms you are giving your consent for the entire school year, which means your child may be seen on the Care-A-Van on more than one occasion. If you wish to withdraw your consent at any time, please follow the protocol on the Notice of Privacy Practices (be sure to include that this is in regards to a "Care-A-Van patient").

What to Expect:
We will review your child's health information from the school and ICARE (Illinois database for vaccine records) to confirm what services your child may need. It is very important that the school has the most current health and immunization records. If your child has NO immunization records available at the time of the visit, we will not give any vaccines unless you write a note on the consent to restart the immunization schedule. We follow the Center for Disease Control and Prevention (CDC) recommended immunization schedule.

After we see your child(ren), we will give your child(ren) information about the services provided on the Pediatric Care-A-Van to take home so that you know exactly what occurred. A copy will also be given to the school for their records. We will also include information about services in the community that you may need (i.e. dentists, primary care providers, etc.).

Information on Vaccines:
Vaccine Information Statements (VIS) are available in multiple languages on the following website: http://www.cdc.gov/vaccines/hcp/vis/index.html. We give vaccines to children up to age 19 who qualify for the Vaccines for Children program, as verified by state records. Vaccines include: Dtap-Infarix, Td-Tenvac, Tdap-Boostrix, Hepatitis A-Havrix, Hepatitis B-Engerix Hib - Pentacel, HPV-Gardisil, Influenza, MMR, Meningococcal-Menactra and Men-B (Bexsero), Pneumococcal-Prevnar, Inactivated Polio, and Varicella (combination vaccines also available: Kinrix, ProQuad, Pediarix and Pentacel). **Your child will only receive the vaccines that are due based on the information provided to us by the school and ICare**. You always have the option to decline any vaccines on the consent. However, please note that many of the vaccines we give are required for your child(ren) to stay in school. We also give recommended vaccines because they are important for keeping your child healthy and may someday become required by the school.

Again, we are Norwegian American Hospital are here to help assist you and your family. If you have any questions, contact your school or call us directly at (773) 292-2629.

Sincerely,
Norwegian American Hospital Care-A-Van

July 2017

NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

NOTICE OF PRIVACY PRACTICES

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

PROTECTED HEALTH INFORMATION

Information about your health is private and it should remain private. That is why this healthcare institution is required by Federal and State laws to protect the privacy of your health information. We call it **"Protected Health Information" (PHI)**.

Staff members, employees and volunteers of this hospital/facility must follow legal regulations with respect to:

- How we use your PHI
- Disclosing your PHI to others
- Your privacy rights
- Our privacy duties
- Contacts for more information, or if necessary, a complaint

USING OR DISCLOSING YOUR PHI

For Treatment

During the course of your treatment, we use and disclose your PHI. For example, if we test your blood in our laboratory, a technician will share the report with your doctor, or we will use your PHI to follow the doctor's orders for an x-ray, surgical procedure or other types of treatment related procedures.

For Payment

After providing treatment, we will ask your insurer to pay us. Some of your PHI may be entered into our computers in order to send a claim to your insurer. This may include a description of your health problem, the treatment we provided and your membership number in your employer's health plan, or your insurer may want to review your medical record to determine whether your care was necessary. Also, we may disclose to a collection agency some of your PHI for collecting a bill that you have not paid.

For Healthcare Operations

Your medical record and PHI could be used in periodic assessments by physicians about the hospital's quality of care. We might use the PHI from real patients in education sessions with medical students training in our hospital. Other uses of your PHI may include business planning for our facility or the resolution of a complaint. We may disclose your information orally, via fax, on paper, or through secure electronic messages and health information exchanges (HIEs). When using PHI for purposes that do not require patient identifiers, we redact identifying information as appropriate.

Special Uses

Your relationship to us as a patient might require using or disclosing your PHI in order to:

- Remind you of an appointment for treatment
- Tell you about treatment alternatives and options
- Tell you about our other health benefits and services

YOUR AUTHORIZATION MAY BE REQUIRED

In many cases, we may use or disclose your PHI, as summarized above, for treatment, payment or healthcare operations or as required or permitted by law. In other cases, we must ask for your written authorization with specific instructions and limits on our use or disclosure of your PHI. You may revoke your authorization if you change your mind later.

CERTAIN USES AND DISCLOSURES OF YOUR PHI REQUIRED OR PERMITTED BY LAW

As a hospital or healthcare facility, we must abide by many laws and regulations that either require us or permit us to use or disclose your PHI.

Required or permitted uses and disclosures

- Your information may be included in a patient directory that is available only to those individuals whom you have identified as contacts during your hospital stay.
- We may use your PHI in an emergency when you are not able to express yourself.
- We may use or disclose your PHI for research if we receive certain assurances, which protect your privacy.

We may also use or disclose your PHI:

- When required by law, for example when ordered by a court.
- For public health activities including reporting a communicable disease or adverse drug reaction to the Food and Drug Administration.
- To report neglect, abuse or domestic violence.
- To government regulators or agents to determine compliance with applicable rules and regulations.
- In judicial or administrative proceedings as in response to a valid subpoena.
- To a coroner for purposes of identifying a deceased person or determining causes of death, or to a funeral director for making funeral arrangements.
- For purposes of research when a research oversight committee, called an Institutional Review Board, has determined that there is a minimal risk to the privacy of your PHI.
- For creating special types of health information that eliminate all legally required identifying information or information that would directly identify the subject of the information.
- In accordance with the legal requirements of a workers' compensation program.
- When properly requested by law enforcement officials, for instance in reporting gunshot wounds, reporting a suspicious death or for other legal requirements.
- If we reasonably believe that use of or disclosure will avert a health hazard or to respond to a threat to public safety including an imminent crime against another person.
- For national security purposes including to the Secret Service or if you are Armed Forces personnel and it is deemed necessary by appropriate military command authorities.
- In connection with certain types of organ donor programs.

YOUR PRIVACY RIGHTS AND HOW TO EXERCISE THEM

Under the federally required privacy program, patients have specific rights.

Your right to request limited use or disclosure

You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request, we must abide by the agreement.

Your right to confidential communication

You have the right to receive confidential communication from the hospital at a location that you provide. You must provide us with the other address in writing and explain if the request will interfere with your method of payment.

Your right to revoke your authorization

You may revoke, in writing, the authorization you granted us for use or disclosure of your PHI. However, if we have relied on your consent or authorization, we may use or disclose your PHI up to the time you revoke your consent.

Your right to inspect and copy

You have the right to inspect and receive a copy of your PHI. We may refuse to give you access to your PHI if we think it may cause you harm, but we must explain why and provide you with someone to contact for a review of our refusal. We may charge a reasonable fee for copying your records.

Your right to amend your PHI

If you disagree with your PHI within our records, you have the right to request, in writing, that we amend your PHI when it is a record that we created or have maintained for us. We may refuse to make the amendment and you have a right to disagree in writing. If we still disagree, we may prepare a counter-statement. Your statement and our counter-statement must be made part of our record about you.

Your right to know who else sees your PHI

You have the right to request an accounting of certain disclosures we have made of your PHI over the past six years. We are not required to account for all disclosures, including those made to you, authorized by you or those involving treatment, payment and healthcare operations as described above. There is no charge for an annual accounting, but there may be charges for additional accountings. We will inform you if there is a charge and you have the right to withdraw your request, or pay to proceed. Contact the Medical Records/Health Information Management Department at 773-292-5966 to request an accounting of disclosures.

SOME OF OUR PRIVACY OBLIGATIONS AND HOW WE FULFILL THEM

Federal health information privacy rules require us to give you notice of our privacy practices. This document is our notice. However, we reserve the right to change this notice and our privacy practices when permitted or as required by law. If we change our notice of privacy practices, we will provide our revised notice to you when you next seek treatment from us.

COMPLIANCE WITH CERTAIN STATE LAWS

When we use or disclose your PHI as described in this notice, or when you exercise certain of your rights set forth in this notice, we may apply state laws about the confidentiality of health information in a place of federal privacy regulations. We do this when these state laws provide you with greater rights or protection for your PHI. When state laws are not in conflict or if these laws do not offer you better rights or more protection, we will continue to protect your privacy by applying the federal regulations.

OUR PARTICIPATION IN ELECTRONIC HEALTH INFORMATION EXCHANGES

We participate in the MetroChicago Health Information Exchange (MetroChicago HIE) to make patient information available electronically to participating hospitals, doctors and other authorized users. We may also receive information about patients from other participants and authorized users in the MetroChicago HIE. In the future we may participate in additional regional, state, or federal HIEs as they are developed.

We expect that using HIEs will provide faster and more complete access to your information so we can make better informed decisions about your care. As described below, you can elect to opt-out and not allow your medical information to be available through any HIE. It is not a condition of receiving care.

The MetroChicago HIE has been structured to comply with federal and state privacy and security laws. Use of MetroChicago HIE is limited to physicians, hospitals, health plans, accountable care organizations, and other authorized users who confirm that they will comply with these laws.

Health information disclosed to MetroChicago HIE may include information regarding your demographics, problem list, diagnosis, treatments, allergies, medications, radiology, and lab information. However, if you received alcohol or substance abuse services from certain treatment centers, that information generally will be excluded from MetroChicago HIE.

Unless you opt-out of MetroChicago HIE, your mental health or developmental disability information (such as diagnosis and medications), HIV/AIDS information, and genetic information (such as test results) may be available to participants and authorized users of the MetroChicago HIE. For more information about how information may be disclosed to MetroChicago HIE and how you may opt-out, please ask registration staff for a copy of the MetroChicago HIE Notice to Patients and Frequently Asked Questions. Additional information is also available at http://www.mchc.com/hie-optout.

RIGHT TO OPT-OUT TO MAKE YOUR HEALTH INFORMATION UNAVAILABLE THROUGH HEALTH INFORMATION EXCHANGES (HIEs)

If you do not want your medical information to be available through HIEs, please contact a staff member in our registration or medical records departments to receive the applicable Opt-Out Form and return it to us.

For the MetroChicago HIE, approximately 24 hours after we process your request, your health care providers will no longer be able to view your medical information through the MetroChicago HIE. Your opt-out will apply to all information in the MetroChicago HIE, even in an emergency. This means that it may take longer for your health care providers to get medical information they may need to treat you.

Even if you opt-out of all HIEs, legal requirements (such as public health reporting) may still be fulfilled through HIEs.

If you opt-out and later decide to reverse that decision, please contact us for a form to reverse your opt-out. Your health information from the period during which you had opted-out may be available through MetroChicago HIE and other HIEs after you reverse your opt-out.

WHAT IF I HAVE A COMPLAINT?

If you believe that your privacy has been violated, you may file a complaint with us or with the Secretary of Health and Human Services in Washington, D.C. We will not retaliate or penalize you for filing a complaint with the facility or the Secretary.

If you have questions about this notice or wish to file a complaint with us, you may contact:

Privacy Officer
Norwegian American Hospital
1044 North Francisco Avenue
Chicago, Illinois 60622
773-292-8200

To file a complaint with the Secretary of Health and Human Services, write to:

200 Independence Avenue, S.E., Washington, D.C. 20201.
877-696-6775

Revised January 2016

NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

Pediatric Care-A-Van Consent and Registration Form

Student's Name: _____ **Date of Birth:** ____ /____ / _____ **Sex Assigned at birth:** ☐M ☐F ☐Intersex
Current Gender: ☐Male ☐Female ☐Transgender-F (MTF) ☐Transgender-M (FTM) ☐Gender Queer ☐Other
Race: ☐ Black/African American ☐Caucasian/White ☐Hispanic/Latino ☐Asian ☐American Indian ☐Other: _____
Phone Number: ( ) _____ - _____ **Type:** ☐Home ☐Cell ☐Work; **Email:** _____
Street Address: _____ **City** _____ **Zip Code:** _____
Parents' Name(s): _____
Legal Guardian? ☐Yes; ☐No (please identify): _____

Child's Health History - Please check box and specify where applicable.

☐No ☐ Yes **Any allergies**? If yes, please list: _____
☐No ☐ Yes **Specific allergy to:** Neomycin, Streptomycin, latex, gelatin, baker's yeast or eggs? (If yes, please circle)
☐No ☐ Yes **Medications**? If yes, please list: _____
☐No ☐ Yes **Do you have any current health concerns about your child?** _____
☐No ☐ Yes **Has your child ever had a reaction to a vaccine?** If yes, please list: _____

*☐No ☐ Yes **Are there any immunizations that you do NOT want your child to receive**? If yes, list: _____

Health Problems: (Check boxes that apply *to your child*. If no response will assume your child has no health problems or issues):

☐Asthma	☐Sickle Cell Anemia	☐Sickle Cell Trait	☐High cholesterol	☐Depression
☐Seizures	☐Broken bone(s)	☐Born premature	☐Diabetes	☐Anemia (low iron)
☐High Blood Pressure	☐Growth Concerns	☐Concussion/head injury	☐Fainting/Passing out	☐ADHD/ADD
☐Heart disease/surgery	☐Anaphylaxis	☐Thalassemia	☐Learning Disabilities	☐Pregnancy (When?)
☐Hemophilia/History of prolonged bleeding				
☐Surgery (type & when): _____			☐NONE OF THE ABOVE	
☐Hospitalized in the last year (specify): _____			☐Other(specify): _____	

Family Information:

☐No ☐Yes **Does the child's parent, grandparent, sibling, aunt or uncle have Diabetes**? Who? _____
☐No ☐Yes **Does the child's parent, grandparent, sibling, aunt or uncle have...** (If yes, circle & write who)

High Blood Pressure Asthma Heart Disease Cancer High Cholesterol Growth Problem

Does your family have...

☐No ☐Yes **A primary care provider (PCP)/ doctor**? Provider's Name: _____
Clinic Information (Name, address, phone number): _____
☐No ☐Yes **A dentist?** Dentist Name _____ Clinic Name/Number: _____
☐No ☐Yes **Insurance?** **Insurance card number** _____ **Needed to ensure you qualify for the FREE vaccine program*

Consent for Services:

As the parent/legal guardian of the above child, I acknowledge that I have received, read and understand the letter to parents, the notice of privacy practices, and this consent/registration form. I give Norwegian American Hospital permission to obtain a medication history of this child if needed. **I also give permission to perform a physical exam, health screenings, and give all recommended and required immunizations.** I acknowledge that the Care-A-Van may visit my child's school more than once in a school year and give permission for my child to be seen at any time. I have received a link to the Vaccines Information Statement (http://www.cdc.gov/vaccines/hcp/vis/index.html). I also give permission for information regarding this medical visit and associated follow up to be shared with my child's school/location and to participate in I Care (Illinois Comprehensive Automated Immunization Registry Exchange). Lastly, I give permission to contact me for follow up.

Signature of Legal Guardian: X_____ **Date:** ___ / ___ / _____
Relationship: _____ **(Consent valid August 1st to July 31st, of current school year)**

Any questions/concerns, please call 773-292-2629

Revised July 2017

CONSENT AND RELEASE OF LIABILITY FOR MEDICAL-RELATED SERVICES PROVIDED BY: [_____]

Name of Student _____ Student ID# _ _ _ _ _ _ _ _ _

Student's Date of Birth _____ School Name _____

1. The undersigned, as the parent or legal guardian of the child named above, understands that [_____], through its network of qualified medical providers ("[_____] **Providers**"), offers medical-related services ("**Services**") to City of Chicago residents including Chicago Public Schools ("**CPS**") students and that my child may be eligible to receive these Services.

2. Because different types of Services are offered by Providers, I understand that each Provider will request my consent prior to having my child receive the following types of Services.

3. I understand that as a substitute caregiver to a Chicago Public School student under the legal guardianship of the Illinois Department of Children and Family Services (DCFS) I am not authorized to provide written Consent for Ordinary and Routine Medical and Dental Care. I further understand that I must request consent from the DCFS Guardianship Administrator, or Authorized Agent, and provide a copy of the DCFS Consent for Ordinary and Routine Medical and Dental Care if consent is granted before any of the above services may be provided.

4. I further grant my consent for the Board of Education of the City of Chicago ("the Board") to release and furnish information_regarding past physical exams, immunizations, chronic conditions, vision and hearing screening, vision exams, hearing exam, and dental exam data in my child's health record to Providers to ensure that the Providers can effectively provide services. I also grant my consent for the Providers to release and furnish reports to my child's school for inclusion in my child's health record, and written and verbal reports concerning the results of any screenings and examinations. I understand that such records still will be subject to the privacy rights afforded by state and federal law.

5. **I understand that the Board has no control over Services provided by a [_____] Provider. Therefore, if a [_____] Provider furnishes the Services, I agree to release and hold harmless the Board, its members, agents, officers, contractors, volunteers and employees from and against any and all claims, demands, actions, complaints, suits or other forms of liability that shall arise out of or by reason of, or be caused by the provision of Services and the treatment received.**

6. I understand that the Provider may bill the Illinois Department of Human Service's Medicaid program or any other currently applicable insurance program for any reimbursable Services it provides and that I may be personally responsible for any co-pay imposed by my insurance company. If you have any questions, call the DHS Helpline at 1-800-843-6154. Persons using a teletypewriter (TTY) can call 1-800-447-6404. The call is free.

The Children and Family Benefits Unit (CFBU) can help you apply for Medicaid and SNAP benefits (food stamps).

Call 773-553-KIDS (5437) for information.

I understand that I may revoke this Consent in whole or in part at any time by sending the Board **and** your child's school prior written notice by fax or mail as follows. This revocation will not take effect for seven (7) business days after the Board receives my notice. Unless I revoke my consent as described above, this Consent will take effect as of the date designated below and it will remain in effect for one calendar year from the date of signature.

The Board of Education of the City of Chicago
Office of Student Health and Wellness
42 W. Madison, Garden Level, Chicago, IL 60602
Attn: Student Health Fax: 773-553-1357

Copy to: Your child's school Attn: Principal

Sign & Date

Parent/Guardian Signature:_____

Printed Name:_____ **Date:** ____/____/____

NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

Tuberculosis (TB) Risk Assessment*

Child's Name: _____ Birthday: _____

1. Does the child have any symptoms of TB (cough, fever, night sweats, loss of appetite, weight loss or fatigue), OR an abnormal chest X-ray? **If YES, circle symptoms** ☐Yes ☐No
2. In the last 2 years, has the child lived with or spent time with someone who has been sick with TB? ☐Yes ☐No
3. Was the child born in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, The Caribbean or the Middle East? **If yes, Date of US arrival:** _____ ☐Yes ☐No
4. Has the child lived or traveled in Africa, Asia, Pacific Islands (except Japan), Central America, South America, Mexico, Eastern Europe, the Caribbean or the Middle East for more than 1 month? **If yes, what country?** _____ ☐Yes ☐No
5. Have any members of the child's household come to the US from another country? **If yes, what country?** _____ ☐Yes ☐No
6. Is the child exposed/lives with a person who: **(If Yes, please circle)** ☐Yes ☐No
   a. Is currently in jail or has been in jail in the past 5 years
   b. Has HIV
   c. Is homeless
   d. Lives in a group home
   e. Uses illegal drugs
   f. Is a migrant farm worker
7. Is the child/teen in jail or ever been in jail? ☐Yes ☐No
8. Does the child have any history of immunosuppressive disease or take any medications that might cause immune-suppression (for example: cancer, sickle cell disease, lupus, HIV)? **If yes, what?** _____ ☐Yes ☐No

X_____ X_____ X_____

(Parent Printed Name) (Parent Signature) (Date)

For Official Use Only:

Reviewed by: _____ Date: _____

Is the child at risk for TB? **Yes** **No**

❑ Referral for Skin Test (PPD) ❑ Referral for CXR due to prior BCG vaccine

Answers on this form will **only be used to determine your child's risk for health problems, especially TB -- a lung disease that is more common in some countries and in people with immune system problems.*

Norwegian American Hospital Care-A-Van
1044 N Francisco Ave – Chicago IL. 60622
Careavan@nahospital.org – (773) 292-2629

NORWEGIAN AMERICAN HOSPITAL
"...Committed to your health"

PHOTO/VIDEO RELEASE FORM

I, _____, consent to the unrestricted use by Norwegian American Hospital (and those acting with its permission and authority) for any and all photographs taken, in whole or in part, unlimited use, for all purposes in any form or medium, including without limitation, its use through or on any electronic media, including the Internet.

I waive any right to inspect or approve the finished product or products or the advertising copy or printed matter that may be used with the finished photograph(s). Further, I relinquish all rights, titles and interests I may have in the finished photograph(s), negative(s) and reproduction to any responsible business firm or publication. It is understood that Norwegian American Hospital retains copyright of images at all times under the express understanding and agreement that Norwegian American Hospital shall have exclusive reproduction rights to the images.

I hereby release Norwegian American Hospital from any and all claims in connection with the photograph(s), including any and all claims of libel.

_____ I am over the age of 18. I have read the above and fully understand its contents.

_____ I am the parent or guardian of a minor. I have read the above and fully understand its contents. I hereby grant permission for my child's photograph(s) to be used in the manner specified above.

Name (please print) _____

Minor's Name(s) if applicable _____

Address/City/State/Zip _____

Telephone _____ Email _____

Signature _____ Date _____

Relation to subject (if subject is a minor) _____