Dear Parent:

St. Louis Children's Hospital's ***Healthy Kids Express*** is a mobile health van that provides free health screenings to children. We will be coming soon to your child's school, community or child care organization. Our goal is to identify possible health concerns or conditions as early as possible, when treatment may be most effective.

Our routine health screenings include tests for hearing and vision.
Services offered on a limited basis include:

- lead and anemia blood testing
- dental screens, cleanings and flouride varnish

Parents are always welcome during the child's health screening.

To help us provide screenings for your child, we need you to complete and sign this health questionnaire and consent form and return it to your child's program.

Please read and initial

1. Release of Information (below)

2. Privacy Practices (back cover)

Because health screenings may show a need for additional care or monitoring, we will share all findings with your child's primary care provider and the enrollment location. As an additional benefit, our team can assist you in accessing other community resources. You may opt out of this additional service at any time through any HKE representative.

Please contact us if you have questions:
314.286.0947 or **HealthyKidsExpress@bjc.org**.

Release of Information

Release of information is not required for your child to be screened. To assist in any care needs for your child, we will forward your child's screening as directed below.

I consent to the St. Louis Children's Hospital Healthy Kids Express use, storage and release of my child's screening records, either electronically or otherwise, created or received by Healthy Kids Express for my child's care and treatment as permitted by law, and specifically to release screening information to the doctor listed in this consent and/or the school involved or who may be involved in my child's care.

Parent/Legal Guardian: please initial _____

Healthy Kids Express
Dental Program
St. Louis Children's Hospital
One Children's Place, 90-67-826
St. Louis, Missouri 63110
314.286.0947 / 314.286.0960 fax
HealthyKidsExpress@bjc.org

Privacy Practices

St. Louis Children's Hospital respects the privacy of your child's health information. To explain how we protect your child's health information, please read the summary of our notice of privacy practices that is printed in this brochure on the back side of the parent letter. If you would like to obtain a copy of our notice, please call us at **314.286.0927** or ask your child's program or the Healthy Kids Express staff for a copy.

My initials below acknowledge that I have been given an opportunity to receive St. Louis Children's Hospital's Notice of Privacy Practices.

Parent/Legal Guardian: please initial _____

This program is made possible by generous donations to the St. Louis Children's Hospital Foundation.

Healthy Kids Express Dental Program
St. Louis Children's Hospital
One Children's Place
St. Louis, Missouri 63110

314.286.0947
314.286.0960 fax

Children's HOSPITAL • ST. LOUIS
BJC HealthCare

HealthyKidsExpress@bjc.org

CS_422731_10/19

Healthy Kids Express
Dental Consent Form

ST. LOUIS CHILDREN'S HOSPITAL

HEALTHY KIDS EXPRESS CONSENT AND MEDICAL HISTORY FORM

Please complete a **Dental Form for each child and return to his/her program**

CHILD'S NAME LAST FIRST MIDDLE INITIAL ☐ MALE ☐ FEMALE DATE OF BIRTH

SCHOOL GRADE/AGE

RACE (optional-check all that apply):

☐ American Indian/Alaskan Native ☐ Asian ☐ Bi or Multi-Racial ☐ Black/African American ☐ Middle Eastern
☐ Native Hawaiian/Other Pacific Islander ☐ White/Caucasian ☐ Unknown ☐ Other _____ ☐ Decline to Answer

ETHNICITY: ☐ Hispanic or Latino ☐ Non- Hispanic or Latino ☐ Unknown ☐ Decline to Answer

PARENT/GUARDIAN NAME LANGUAGE SPOKEN IN HOME PREFERRED WRITTEN LANGUAGE

HOME ADDRESS STREET APT # CITY STATE ZIP CODE

HOME PHONE (INCLUDE AREA CODE) CELL/PAGER WORK PHONE EMAIL ADDRESS (optional)

NAME OF EMERGENCY CONTACT CELL/HOME PHONE WORK PHONE RELATIONSHIP TO CHILD

NAME OF DOCTOR/CLINIC PHONE NAME OF DENTIST/CLINIC PHONE

DOES YOUR CHILD HAVE HEALTH INSURANCE: ☐ NO ☐ YES…NAME OF INSURANCE PROVIDER: _____

DOES YOUR CHILD RECEIVE FREE OR REDUCED SCHOOL LUNCH: ☐ NO ☐ YES

I have read and understand the nature of the screening services offered to my child and have completed all blanks and/or sought answers to my questions (if any) related to the screenings. I authorize and consent for my child to participate in the indicated screening(s) by my signature below.

PARENT/GUARDIAN SIGNATURE **DATE** [CONSENT IS VALID FOR ONE YEAR]

IF YOU *DO NOT* WANT SCREENINGS FOR YOUR CHILD, PLEASE CHECK THIS BOX. ☐ *[No signature needed]*

PLEASE CHECK THE SCREENING SERVICES YOU WOULD LIKE FOR YOUR CHILD:

☐ **DENTAL EXAM*** with fluoride varnish if applicable (3 years and up)

*** For Dental - PERMISSION TO GIVE IBUPROFEN** ☐ Yes ☐ No

NOTE: Release is not required for your child to obtain a screening but assists in coordinating care/treatment of your child with other providers

MEDICAL HISTORY - PLEASE CHECK IF YOUR CHILD HAS ANY OF THE FOLLOWING:

☐ ANEMIC (Low iron in blood) ☐ EYE PROBLEMS/SURGERY ☐ FREQUENT EAR INFECTIONS ☐ ASTHMA ☐ CONGENITAL HEART DEFECT
☐ LEAD (History of high levels) ☐ WEARS GLASSES ☐ EAR SURGERY (TUBES PLACED) ☐ HIV/AIDS ☐ MENTAL/PHYSICAL DISABILITY
☐ HIGH BLOOD PRESSURE ☐ SICKLE CELL DISEASE ☐ HEARING PROBLEMS/HEARING AIDS ☐ BLEEDING DISORDER ☐ PREGNANT
☐ **NONE OF THE ABOVE** ☐ OTHER: _____

PLEASE EXPLAIN ANY ITEM CHECKED ABOVE:

_____

HOSPITALIZATIONS: _____ SURGERIES: _____

LIST ANY MEDICATIONS YOUR CHILD TAKES: _____

LIST ANY ALLERGIES YOUR CHILD HAS: ☐ LATEX ☐ SEASONAL ☐ FOOD: _____ ☐ DRUG: _____

PLEASE LIST ADDITIONAL CONCERNS YOU MAY HAVE ABOUT YOUR CHILD: _____

Barnes-Jewish Hospital BJC HealthCare

Washington University in St. Louis Physicians

Children's Hospital · St. Louis BJC HealthCare

Your privacy matters

Safeguarding your health information is important to us. As providers who often work together to provide you with care, we have developed certain practices to help protect your health information.

In general, our privacy practices describe how, when and why we may use and disclose your health information, as well as your rights with regard to your health information.

Our Notice explains and informs you of our privacy practices. You are entitled to receive and review our full-length legal Notice of Privacy Practices. You may obtain a copy of our Notice on our website at www.bjc.org or www.WUPhysicians.wustl.edu; at any of our hospitals, nursing facilities or medical offices; or by calling 314-867-3627.

The Health Insurance Portability and Accountability Act of 1996, which is the federal law commonly known as "HIPAA," provides certain protections for any of your health information that can be specifically identified as yours. HIPAA permits and our privacy practices allow us to use your individually identifiable health information or share it with another health care provider or an insurance company in the following circumstances:

- To treat and care for you, including contacting you for appointment reminders
- To obtain payment from you or your insurance company
- In connection with our health care operations, which are operational activities typically carried out by health care providers, such as quality assessment and improvement, review and/or training of health care professionals, business planning, customer service, grievance resolution and other general administrative activities

HIPAA also allows us to use certain health information for the following activities:

- For our fundraising purposes (You have the right to opt out of receiving those communications.)
- When required by law
- When permitted by HIPAA for activities including:
  - Public health and safety
  - Health oversight agencies for monitoring of the health care system
  - Law enforcement related to its criminal investigations
  - Judicial and administrative proceedings
- Organ donation
- For research (provided other precautions are taken regarding your information)
- We will also follow other federal and state laws when they provide extra protections regarding your health information.

If our use or disclosure is not for one of the activities described above and is not otherwise permitted under HIPAA, we will ask you to complete a written authorization before we use or release your health information. The authorization will:

- Describe in detail the health information it covers
- Identify to whom your health care information will be released and how it will be used
- Describe when it will be used or released
- State the expiration date of the consent

When receiving services from us, you will also be able to decide whether to remain listed in our patient directory and whether we can discuss your health information with your family or friends. Even if you have provided us with your authorization, you may withdraw that authorization, in writing, at any time to stop our future disclosures of your health information. Information disclosed before you revoked your authorization will not be returned and any actions that we have already taken based on prior authorizations will not be affected.

Your rights regarding your health information

HIPAA provides you with the following rights regarding your health information:

1. **Restricting a Use/Disclosure** You may request a restriction on how we use or disclose your health information. You may request in writing that we not share your information with a health care plan for services that you have paid for in full out of pocket. Any approved restriction may only be followed to the extent permitted by law.
2. **Requesting Confidential Communications** You may request reasonable changes in how or where we may contact you to remind you of an appointment, for lab results or other health information.
3. **Inspecting and Obtaining Copies of Your Health Information** You may ask, in writing, to look at and/or obtain a copy of your health information. There may be a fee associated with your request.
4. **Requesting a Change in Your Health Information** You may request, in writing, a change or addition to your health information. The law limits the types of changes that may be made and we may not erase or delete any information in your records.
5. **Requesting an Accounting of Disclosures of Your Health Information** You may ask, in writing, for an accounting of certain types of disclosures made of your health information. Disclosures made with your authorization will not be included in the accounting.
6. **Receiving Notifications in the Event of a Breach of Unsecured Protected Health Information** You will be notified in writing in the event there is an unintended disclosure of your health information. We also will share any steps that were taken to reduce the impact of the disclosure and what you can do to further protect yourself.

We welcome an opportunity to address any questions or concerns that you may have regarding the privacy of your health information. If you believe that the privacy of your health information has been violated, you may contact us to discuss your concern or to file a complaint.

For questions or requests concerning Barnes-Jewish Hospital or St. Louis Children's Hospital, please contact our Patient or HIPAA Liaisons through the operator at:

Barnes-Jewish Hospital 314.362.5000
St. Louis Children's Hospital
314.454.6000

For questions or requests concerning Washington University or its providers, please contact the Privacy Officer at **1.866.747.4975** or Campus Box 8098, 660 S. Euclid Ave., St. Louis, MO 63110.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services:

U.S. Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Be assured that filing a complaint or voicing a privacy concern will not impact your care in any way.

Our Notice's latest effective date:
April 14, 2003
Revised: July 1, 2013