RUSH

General Informed Consent

IDN13150039

RUSH SCHOOL BASED HEALTH CENTERS (RSBHC) MINOR ENROLLMENT CONSENT FORM FOR REPRODUCTIVE AND MENTAL HEALTH SERVICES

For Adolescents 12-17 Years of Age

STUDENT/PATIENT INFORMATION

Legal Name: _____ **Preferred Name:** _____
Last First Middle Initial Last First Middle Initial

Sex Assigned at Birth: ☐ Female ☐ Male

Gender Identity (select all that apply): ☐ Female ☐ Male ☐ Transgender ☐ Non-binary ☐ Other: _____

Pronouns Used: ☐ she/her/hers ☐ he/him/his ☐ they/them/theirs ☐ Patient's name ☐ Decline to answer ☐ Unknown ☐ Other: _____

Date of Birth: _____ **Social Security #** _____ – _____ – _____

Race/Ethnicity: ☐ African American/Black ☐ American Indian/Alaskan Native ☐ Asian
☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Two or more races ☐ White

Home Phone: (_____) _____ Cell Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

School Name/Attending: _____ Grade _____ Division/Home Rm#_____

PARENT/LEGAL GUARDIAN INFORMATION

Name: _____ Relationship _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Cell Phone: (_____) _____ Pager Number: (_____) _____

EMERGENCY INFORMATION

Name of Contact 1: _____ Relationship to Student _____

Telephone 1 (_____) _____ Telephone 2 (_____) _____

Name of Contact 2: _____ Relationship to Student _____

Telephone 1 (_____) _____ Telephone 2 (_____) _____

INSURANCE INFORMATION

Type of Insurance: ☐ Medicaid ☐ HMO ☐ PPO ☐ No Insurance ☐ Other: _____

Specific Medicaid/All Kids Information: Recipient ID: _____ Case #: _____

Specific MCO/PPO/Other Information: Name of MCO/PPO/Other: _____

Name of Insured: _____ Date of Birth: _____

Policy ID Number: _____ Group # _____

Policy Holder Employer: _____ Address: _____ Phone: (_____) _____

PRIMARY CARE PROVIDER INFORMATION

Doctor's Name: _____ Clinic Name: _____

Address: _____ Doctor's Phone # (_____) _____

Allergies to Medicine(s) _____ Existing Medical Condition(s)_____

MINOR CONSENT FOR CONFIDENTIAL REPRODUCTIVE AND MENTAL HEALTH SERVICES

The staff of the RSBHC considers parental involvement vital. Every student is encouraged to involve parent(s)/guardian(s) in healthcare decisions. However, under Illinois law, persons from 12 to 18 years of age can consent to receive certain health services including: birth control, pregnancy tests, STD testing and treatment, HIV testing, HPV and Hep-B vaccines, pregnancy related care, and psychotherapy or other mental health counseling services. Accordingly, confidentiality between the student and healthcare providers will be respected in these specific service areas designated by law, and will not be discussed with parent(s)/guardian(s) unless agreed upon by the student. The table below describes the types of confidential services available to you. The Health Center can provide a wide range of services with a signed parent consent on file. Please ask RSBHC staff for more details.

Confidential services available will include but not be limited to the following:

Laboratory Services • Pregnancy tests • STI testing and treatment • HPV and Hep-B vaccines** • Blood testing	**Mental Health Services** • Assessment of stress, depression and adjustment difficulties • Assessment of alcohol & drug problems • Counseling for emotional & behavioral issues (up to eight (8) 90-minute sessions before parental consent is required unless otherwise authorized by law) • Individual, group & family counseling
Reproductive Health Services • Abstinence, pre-conception, pregnancy options counseling • Education/diagnosis/treatment for sexually transmitted infections • Menstrual problems • Contraception drugs & devices/exams/provision/prescriptions • Pap Smears • Pregnancy services-tests, prenatal care • Cancer screening & education	**Referrals/Follow Up** **Health Education Programs**

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

As a patient of the RSBHC, I understand that, unless an exception is authorized by law, RSBHC staff may not inform my parent(s) or guardian of the fact that I am receiving these services without my permission or release any information about me receiving any of the confidential services described in this consent to **anyone** without my permission. The following list contains examples of situations when RSBHC staff may be required to disclose information about me without authorization:

1) An injury or accident happens on school property.

2) I tell them that I am being physically or sexually abused.

3) I have done harm or could do harm to myself or someone else.

Should RSBHC staff determine that disclosure to my parent or guardian is necessary for reasons of safety, I understand that the staff member will make every attempt to notify me prior to contacting my parent or guardian.

Just as the staff in the RSBHC agrees to protect my confidentiality, I agree to respect the confidentiality of all other students that I may see in the RSBHC. This means that if I see another student in the Health Center and/or I hear information about someone that may be personal, I agree to keep that information to myself and tell no one else.

I further understand that discussions I have with the staff are confidential and the medical records maintained by the staff are confidential. I have the right to refuse any service offered by the RSBHC at any time. I understand that I must notify the RSHBC staff in the event my address or telephone number changes.

MINOR CONSENT FOR REPRODUCTIVE HEALTH CARE

I agree to receive reproductive or mental health services at the Rush School Based Health Centers. According to Illinois law, **Persons from 12 to 18 years of age can consent to receive certain health services including: birth control, pregnancy tests, STD testing and treatment, HIV testing, HPV and Hep-B vaccines, and pregnancy related care and counseling.**

As I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

Signature of Adolescent Patient _____ **Date:** _____

Witness _____ **Date:** _____

MINOR CONSENT FOR MENTAL HEALTH CARE

I agree to receive mental health services at the Rush School Based Health Centers. According to Illinois law, **Persons from 12 to 18 years of age can consent to receive certain mental health counseling or psychotherapy services for a limited number of sessions. After the final session, in consultation with the minor, the mental health provider can determine whether attempting to obtain parental/guardian consent would be detrimental to the minor's wellbeing.**

As I am under the age of 18 years and not legally independent from my parents, I understand that this consent applies only to the services listed above. I also understand that I may withdraw my permission at any time.

Signature of Adolescent Patient _____ **Date:** _____

Witness _____ **Date:** _____

INTERPRETER UTILIZED / INTÉRPRETE UTILIZADO

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Print Name of Interpreter / Qualified Bilingual Staff / or the Identification Number of the Telephonic Interpreter