General Informed Consent

IDN13150039

SCHOOL BASED HEALTH CARE CENTERS PARENTAL/GUARDIAN CONSENT FORM FOR HEALTH SERVICES

STUDENT INFORMATION

Name: ____ **Sex:** ☐ Male ☐ Female
Last First Middle Initial

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: __________

School Attending: ____ Grade in School _________ Division #________

PARENT/LEGAL GUARDIAN INFORMATION

Name: ____ **Date of Birth:** ____________________

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/All Kids ☐ HMO ☐ PPO ☐ No Insurance ☐ Other: __________________________

Specific Medicaid/All Kids Information: Recipient ID: ____________________________ Case #: ____________________

Specific HMO/PPO/Other Information: Name of HMO/PPO/Other: ____

Name of Insured: ____________________________________ Policy ID Number:____________ Group #_____________

Employer Name: ____________________ Address: _________________________ Phone: (_____) _____________

PRIMARY PHYSICIAN INFORMATION

Student's Doctor's Name: ____________________________ Clinic Name: ________________________________

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

Allergies to Medicine(s) ______________________________ Existing Medical Condition(s)______________________

I authorize and consent to the enrollment of the above-named minor, of whom I am the parent or guardian, in the Health Center. My consent will allow the professional staff of the Health Center to provide comprehensive medical and counseling services to my child during attendance at school. My child has a right to refuse any service provided in the Health Center and I have a right to withdraw my consent and refuse services by notifying the Health Center staff in person. Comprehensive medical care includes those services my child would receive in a doctor's office or a clinic. Such services may include, but are not limited to, school and sports physicals, care of existing medical conditions (such as, diabetes, high blood pressure, asthma), treatment of acute medical problems (such as, sore throats, colds, stomach aches), immunizations and vaccinations (including Hepatitis A, Hepatitis B, Hib, HPV, Polio, Meningococcal, MMR, Pneumococcal, Seasonal Flu, Tdap, TD), TB Testing, health education and first aid. I further consent to the performance of medically prescribed lab tests (that may require blood or urine samples) that may be prescribed as part of my child's medical care. I understand, that under Illinois law, my child may consent to certain types of services, including pregnancy testing, birth control methods and treatment of infections resulting from having sex and that these services are available at the Health Center. I understand that the professional staff at the Health Center may encourage the practice of abstinence (not having sex) in discussions with patients. I understand that no medical experimentation will be conducted on my child. I further understand that the medical records maintained by the staff are confidential and are the property of the Health Center. I authorize the health center staff to release school and sports physical forms and immunization records to your child's School. I authorize the Chicago Public Schools to release the records of previous physicals and immunizations pertaining to my child for use by the Health Center staff.

Signature of Parent/Legal Guardian X ____ **Date:** ______________

Relationship to Student: ______ Mother ______ Father _____ Other (specify) ________________________________