URBANA SCHOOL HEALTH CENTER

PARENTAL/GUARDIAN CONSENT FORM FOR ALL SERVICES

The Urbana School Health Center consists of a seamless partnership of trusted local agencies dedicated to the health and well being of your child. The partnership includes; the Urbana School District #116, the Champaign-Urbana Public Health District, Frances Nelson Community Health Center, the Mental Health Center of Champaign County, and the Prairie Center Health Systems. A Physician, Nurse Practitioner or Physician Assistant, Dentist, Dental Hygienist, Nurse, Mental Health Counselor, Social Worker, and Nutritionist are available, based on schedules, to provide primary health care, dental care, psychosocial services and nutritional consultation to ALL students enrolled in the Urbana School District.

Available services may include, but are not limited to:

1. Physical examination, health assessments, screening for health problems
2. Diagnosis and treatment of acute illness and injury
3. Diagnosis and management of chronic illness
4. Health education and promotion. Outreach health promotion/prevention workshops will be offered
5. Immunizations
6. Wellness promotion including smoking cessation, nutrition, weight management
7. Reproductive health care including; gynecological examinations with PAP smears, STD education, testing, and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
8. Laboratory tests including throat cultures, complete blood counts, mono spots etc.
9. Mental Health counseling services
10. Dental examination and treatment
11. Referrals to other linkage agencies for services not provided at the School Health Center

PARENTAL/GUARDIAN CONSENT

The aforementioned child has my consent to receive services offered at the Urbana School Health Center located in Urbana High School by its contracted providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing the Health Center to provide services to my child in his/her best interest.

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 consent to the release of relevant health information and medical records in connection with treatments to the School Health Center and its collaborating partners to facilitate my child's health needs. I further authorize the School Health Center to release information regarding my child's treatment to third party payors or others for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

I authorize Urbana School Health Center to release my child's immunization record and a copy of any Certificate of Child Health Examination form completed by the Urbana School Health Center to the Urbana School District. I authorize the Urbana School District to release immunization records to the Urbana School Health Center.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services at the Urbana School Health Center, he/she may receive up to five therapy sessions without my consent. I am aware that a separate parental consent form will need to be signed for substance abuse services. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

Signature of Parent/Guardian_____ Date_____

Signature of Client (12yrs or older) _____ Date_____

Assignment of Insurance Benefits

I hereby authorize payment to the Urbana School Health Center and its contracted providers for Center's usual and customary cost of treatment otherwise payable to me, but not to exceed the Center's regular charges. I understand that I am financially responsible to the Urbana School Health Center and it contracted providers for the charges not covered by my insurance plan.

Authorizing Signature – Parent/Guardian_____ Date_____

Rev. 10/08

URBANA SCHOOL HEALTH CENTER

STUDENT/PATIENT INFORMATION **Child's School**_____ **Grade**_____

Name: _____ **Birthdate:** _____ ❒ **Female** ❒ **Male**
Last **First**

Parent/Guardian Name: _____

Parent/Guardian Address: _____
City **State** **Zip**

Telephone: Home_____ **Work**_____ **Employer**_____

Emergency Contact_____ **Relationship to child**_____ **Telephone**_____

DOCTOR OR OTHER HEALTH CARE PROVIDER

❒ Frances Nelson Community Health Center ❒ Champaign-Urbana Public Health District

❒ Carle Clinic ❒ Christie Clinic ❒ Other_____

Telephone Number of Doctor or Other Provider _____

RACE

❒ American Indian ❒ Asian ❒ Hawaiian/Pacific Islander
❒ Black/Hispanic ❒ Black/Non-Hispanic ❒ White/Non Hispanic ❒ White/Hispanic
❒ Mixed Race ❒ Unknown

PREFERRED LANGUAGE

❒ English ❒ Spanish ❒ Other (specify) _____

❒ YES, WE HAVE INSURANCE

IF YOU HAVE HEALTH INSURANCE PLEASE ATTACH A COPY OF YOUR INSURANCE CARD (FRONT & BACK)

❒ MEDICAID/ALL KIDS/KIDCARE ❒ HMO ❒ PPO/POS ❒ Indemnity/Fee for Service

Name of insurance company _____

❒ NO, WE DO NOT HAVE INSURANCE

Do you qualify for the Free and Reduced Rate School Lunch Program? ❒ YES ❒ NO ❒ Don't Know