CONSENT FORM

Maple Street School-Linked Health Center

(please print and be sure to fill out the entire form)

Name of Student _____
Last First MI

Sex ☐ Female ☐ Male Date of Birth _____Social Security # _____

Address_____
Street City State Zip

Number of people in household _____

Name of Parent/Guardian _____

Telephone: Home ( ) _____ Work ( )_____ Employer _____

Name of Emergency Contact _____ Relationship to student _____

Emergency Contact's Telephone ( ) _____

Doctor or Other Health Care Provider _____ Telephone ( )_____

Housing Status: ☐ Own ☐ Rent ☐ Homeless ☐ Other _____

Race ☐ Asian ☐ Black ☐ White Hispanic ☐ Black Hispanic ☐ Native American/Aleutian
☐ White ☐Hawaiian/Pacific Islander ☐Mixed Race ☐ Other (Specify) _____ ☐ Unknown

Ethnicity_____ (Examples: African, British, Chinese, French, German, Hispanic, Italian, Irish, Korean, Mexican, Etc.)

Eligibility: Name of Student's School _____ Grade _____

☐ **NO** Insurance
☐ Currently **applying** for Insurance Name of Insurance _____

or if you **have Medical Coverage**, Please complete the following information

☐ AllKids Recipient ID# _____

☐ Private Health Insurance or HMO Name of Insurance _____

Name of Insured (I.e. Parent/guardian) _____

Social Security #/ID of insured _____ Policy # _____ Group # _____

Phone Number of Insurance Company or HMO _____

A complete range of services are provided
by the Macoupin County Community Care School Linked Health Center

- Well child exams complete with appropriate immunization, laboratory tests, and review of future child health topics such as developmental or social milestones.
- School physicals
- Sport physicals
- Immunizations, TB Skin Tests
- Management of Chronic Conditions (such as Asthma, Diabetes, etc.)
- Emergency Care & Referrals
- Treatment for illnesses and injuries
- Help with medications
- On-site simple lab tests (such as hemoglobin, blood sugar, lead and lipid profile)
- Health Education & Counseling (abstinence, nutrition, fitness & hygiene, risky behaviors, violence prevention, safety, and self-esteem)
- Medical, dental, mental health and social service referrals.

Parental Consent

The above named student has my consent to receive services offered by the Macoupin County Community Care School-Linked Health Center located in Gillespie, IL. I have been informed of and understand the scope of services to be provided to the student.

I also consent to the release of relevant health information to the Macoupin County Community Care School Linked Health Center in order to facilitate evaluation of my child's health needs. I further authorize the School-Linked Health Center to release information regarding my child's treatment to third party payors or others for the purposes of billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality. I further authorize my child's school district, _____, to release to the SLHC information regarding my child's address and phone number for the purpose of maintaining the SLHC's data base.

I acknowledge the receipt of the Macoupin County Public Health Department's Notice of Privacy Practices (effective date April 14, 2003) on the date stated below.

I understand that I may revoke this consent in writing at any time, but that revoking this consent will not cancel what was done before I revoked the consent. I also understand that I have the right to refuse services at any time.

For minor participants:

_____ _____
Signature of Parent/Legal Guardian ONLY Date

For students who are legally permitted to give consent for his/herself:

_____ _____
Signature of Student Date

04/27/09