Maple Street Clinic
109 E. Maple
Gillespie, IL 62033
217-839-1526 – Medical/Behavioral
217-839-4110 – Dental

Morgan Street Clinic
1115 Morgan Street
Carlinville, IL 62626
217-854-3692 – Medical/Behavioral
217-854-6823 – Dental

CONSENT TO TREATMENT FOR A CHILD

Maple Street Clinic requires that all parent/legal guardians bring their child to their first appointment. This is necessary to complete all forms and to sign consent for treatment. Consent to treatment allows those names listed to bring the child to our facility for treatment. However, a parent/legal guardian must bring the child to any appointment requiring an extraction in dental or a medication change in behavioral health. The below named individual(s) will provide information regarding my child's health, allergies, immunization contraindications, previous reactions to immunizations, and all medication currently being taken. The staff at Maple Street Clinic and Morgan Street Clinic (School Linked Health Centers) has my permission to treat my child and/or provide all needed immunizations, dental, medical, behavioral health care.

I understand that this form must be updated once per year.

Please sign the following consent if your child may be brought to his/her appointment by another adult (over 18 years of age).

I, ______________________________, hereby give my consent for treatment and/or immunizations of
(Parent/Legal Guardian)

______________________________ **DOB** __________ **by the staff at Maple/Morgan Street Clinics.**
(Child's Name)

I give the consent for the following adults to bring my child to his/her medical, dental, or behavioral health appointments:

1. ______________________________ ______________________________
(Name of adult) (Relationship to child)

2. ______________________________ ______________________________
(Name of adult) (Relationship to child)

3. ______________________________ ______________________________
(Name of adult) (Relationship to child)

______________________________ ______________________________
(Signature of Parent or Legal Guardian) (Date)

______________________________ ______________________________
(Witness) (Date)

Updated 7/22/19

Maple Street/Morgan Street Clinics-School-Linked Health Centers

Patient Name: ____ Date of Birth: _______________________

Available services include, but are not limited to:

- Well child exams complete with appropriate immunizations(s), laboratory test(s), and review of future child health topics such as developmental or social milestones
- School and Sports physicals
- Immunizations, Lead, and TB skin tests
- Management of chronic conditions (Asthma, Diabetes, etc.)
- Treatment for acute illnesses, injury, and behavioral health crisis
- Help with medications
- On-site simple lab test (Hemoglobin, blood sugar, lead, lipid profile, etc.)
- Health education and counseling (abstinence, nutrition, hygiene, risks, safety, self-esteem, resiliency, etc.)
- Routine medical and mental health services
- Medical, dental, mental health, and social service referrals
- Routine dental care including extractions and sealants

Parental Consent

The above-named student has my consent to receive services offered by the Macoupin County Maple Street Clinic, located in Gillespie, Illinois and the Macoupin County Morgan Street Clinic, located in Carlinville, Illinois. I have been informed of an understand the scope of services to be provided to the student. I understand that under Illinois law, a minor age twelve (12) and over has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. These services include up to five (5) therapy sessions without my consent. I am aware that a separate parental consent form will need to be signed for mental health/substance abuse services. By law, a child under the age of twelve (12) will not be allowed to receive mental health/substance abuse services without parental consent.

I also consent to the release of relevant health information to the Macoupin County Maple Street Clinic and Morgan Street Clinic, School-Linked Health Centers 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 payers 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 School-Linked Health Center regarding my child's address and phone number for the purpose of maintaining the School-Linked Health Center's database.

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 signed)

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

____ _______________________

(Signature of Student) (Date signed)