NorthShore
University HealthSystem

EVANSTON TOWNSHIP HIGH SCHOOL
SCHOOL-BASED HEALTH CENTER
PARENTAL/ADULT CONSENT FOR HEALTH SERVICES

49330-003 (1/2021)

PARENTAL/ADULT CONSENT

I authorize and consent to the enrollment of the minor named below, of whom I am the parent or guardian, in the ETHS Health Center. My consent will allow the professional staff of the Health Center to provide comprehensive medical care and counseling services to my child. I understand that my child has a right to refuse any service provided in the Health Center, and with the exception of those services guaranteed under Illinois law, I have a right to withdraw my consent and refuse all services by notifying the Health Center staff in writing. I understand that under Illinois law my child may consent to certain mental health and reproductive health services, and that these services are available at the Health Center.

Comprehensive medical care may include, but is not limited to, care of acute and chronic illness and injury, physical examinations or checkups, immunizations, health education, laboratory testing, reproductive health care, social work services, and psychological counseling and referrals.

I further understand that confidentiality between my child and health care providers will be ensured in specific service areas designated by the law, and that services in these areas will not be discussed with the parent/guardian without my child's consent.

I understand that the results of the school and sports physicals and immunizations may be shared reciprocally with Evanston Township High School. I further authorize the release of information regarding my child's treatment to third party payors for the purpose of billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality.

STUDENT INFORMATION

Student's Name: _____ Birth date: _____/_____/_____ ID# _____

Graduation Year: 20___ Race (optional):_____ Ethnicity (optional):_____ Gender Identity:____ Sex Assigned at Birth:____

Address: _____ Zip Code: _____

Name of Parent/Guardian: _____ Relationship to Student: _____

Student Cell: (____) _____ Student E-mail:_____

Parent Cell: (_____) _____ Parent/Guardian E-mail: _____

Emergency Contact: _____ Relationship to Student:_____ Phone: (____) _____

(other than parent/guardian):

INSURANCE INFORMATION

Insurance Type: Private _____ Medicaid _____ None _____

If student has Medicaid, what Health Plan is he/she enrolled in?: _____

Student's Primary Care Provider (PCP)*: _____ Phone: (_____) _____

Do you qualify for the Free or Reduced Rate School Lunch Program? Yes _____ No _____ Don't know_____

Signature: X_____ **Date:** _____

Relationship to patient:_____

Please fill out other side of this form
MUST USE BLACK BALLPOINT PEN

NOTICE OF HEALTH INFORMATION PRACTICES

I acknowledge that I have received NorthShore University HealthSystem's *Notice of Health Information Practices*.

Signature: X_____ Date: _____
(Patient's or Parent/Guardian's Signature)

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment to be made to the ETHS Health Center and its contracted providers for the Center's expense benefits otherwise payable to me, but not to exceed the Center's regular charges. I understand that I am financially responsible to the ETHS Health Center and its contracted providers for the charges not covered by my insurance plan.

Signature: X_____ Date: _____

PERMISSION TO USE SCHOOL ISSUED EMAIL

I give the ETHS Health Center permission to use my child's school-issued e-mail as needed, with the understanding that e-mail is not a secure and confidential method of communication.

Student ETHS E-mail: _____

Signature: X_____ Date: _____

PLEASE HAVE INSURANCE CARD AT TIME OF VISIT

THANK YOU!

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