NorthShore
University HealthSystem

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

49330-003 (12/2015)

STUDENT DATA

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

Graduation Year: 20 _____ Race (optional): _____ Ethnicity (optional)_____ Sex: M F

STREET:	ZIP CODE:	HOME:	WORK:	PARENT CELL:	STUDENT CELL:

Name of parent/guardian: _____ Relationship to Student: _____

Birth date of parent/guardian: _____ Parent/Guardian email: _____

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

INSURANCE DATA

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_____

PARENTAL/ADULT CONSENT

I authorize and consent to the enrollment of the above-named minor, 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 services by notifying the Health Center staff in writing. I understand that under Illinois law my child may consent to certain types of services, including mental health and reproductive health, and that these services are available at the Health Center.

Comprehensive medical care includes those services my child would receive in a doctor's office or clinic. Such services may include, but are 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 the student 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 unless the student agrees.

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.

Signature: X_____ **Date:** _____

Relationship to patient:_____

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 Personal Representative Signature)

Relationship to patient:_____

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 school issued email for healthy messages.

Student ETHS Email: _____

Student Signature: X_____ **Date:** _____

PLEASE PROVIDE YOUR INSURANCE CARD WHICH WE WILL COPY AND GIVE BACK TO YOU.

THANK YOU!

MUST USE BLACK BALLPOINT PEN