DISTRICT 207 SCHOOL-BASED HEALTH CENTER
PARENTAL/GUARDIAN CONSENT FORM FOR HEALTH SERVICES

Name of Student _____ School ID# _____
Last First

School _____ o Freshman o Sophomore o Junior o Senior

Ethnicity _____ o Male o Female

Address _____ Date of Birth _____
Street Address City State Zip

Name of Parent/Guardian _____

Telephone: Home ( ) _____ Father's Work ( ) _____ Mother's Work ( ) _____

Emergency Contact _____ Relationship to student _____ Tel ( ) _____

Student's Doctor or other Health Care Provider _____ Tel ( ) _____

Allergies to Medicine _____

Do you have insurance coverage for medical services? o Yes o No
If yes, what type of insurance coverage?

State Medicaid o Yes o No If yes, Recipient ID# _____

AllKids o Yes o No If yes, Recipient ID# _____

Private Health Insurance or HMO o Yes o No
If yes, please complete:
Name of Insurance Company _____
Name of insured _____
ID of insured _____
Policy Number _____ Group Number _____
Address of Insurance Company or HMO _____

PARENTAL/GUARDIAN CONSENT

The above-named student has my consent to receive services offered by the School-Based Health Center located in Maine East High School. I have received a list of the services available at the School-Based Health Center and understand and consent to the scope of services that the student may receive. I further understand that the services available through the School-Based Health Center are not intended as primary care, and are not a substitute for parental monitoring of the student's health or regular visits to a primary care physician.

Confidentiality of student records and medical information will be maintained as required under the relevant federal and State laws and regulations.

I consent to the release of relevant health information about the student to Advocate Medical Group to facilitate evaluation of the student's health needs and to further medical services provided to the student at the School-Based Health Center. I authorize the School-Based Health Center to release information regarding my child's treatment to third party payers or others for purposes of billing, program management and evaluation in accordance with all federal and State laws and regulations. I further authorize for the release of any immunization records or copy of Child Health Examination record between the School Based Health Center and District 207 High Schools.

Signature of Parent/Guardian _____ Date _____

Relationship to Student: o Mother o Father o Other (specify) _____