SchoolHealthLink

3602 Avenue of the Cities · Moline, IL 61265
Phone: (309) 743-1470 Fax: (309) 743-1472

Patient Information and Consent

Child Legal First Name_____ Child Legal Last Name_____ Preferred First Name _____

Date of Birth_____ Age_____ Gender_____

School Student Attends_____ Current Grade_____ Race/Ethnicity_____

Parent/Legal Guardian Name_____ Phone_____ Email_____

Address_____ City_____ State_____ Zip _____

Who else may be accompanying the child to appointments? Please list by name and relation: _____

The State of Illinois Requires

The information below must be filled out regardless of your *Insurance Status* Practices

What is the approximate gross yearly household income? _____

Indicate the total number of people in the household: _____

Head of household (circle): Male Female

Father's Employer_____

Mother's Employer _____

If your child has Illinois Medical Card/ALL KIDS Medical Insurance, please complete the following:

Case ID Number _____

Recipient Number _____

If you have applied for ALL KIDS: Date applied:_____ Where you applied:_____

If your child's health care is covered by Private/Commercial insurance, please complete the following:

Insurance Company _____

Insurance Phone Number (back of insurance card) _____

Member ID: _____

Policy Holder: _____

Policy Holder Date of Birth: _____

****If your child DOES NOT have medical insurance, please check the following:**

____I am attesting that I do NOT have any insurance, private or otherwise listed, for the date of service for my child. I understand that falsifying this information is a violation in accordance with the rules of VFC (Vaccines for Children). I agree to pay _____ for the school physical and $15 for each vaccine if required regardless of changes in insurance status. ****For children attending school physical clinics: payment for physical and required vaccines is expected on day that physical and/or vaccines will be performed. Cash or check is accepted****

Consent and Acknowledgement

Receipt of Joint Notice of Privacy Practices

I,_____(patient or legal guardian name) do hereby consent to allow School Health LINK Inc. and its designated employees/contractors to perform a medical evaluation and treat conditions judiciously. I understand the nature and consequences of any procedures to be performed will be explained to me. I understand that School Health LINK Inc. is already authorized to use the information gained during treatment to bill me, my insurance company, or any other potential sources of reimbursements, such as government programs in which I am enrolled or qualify for services. I also hereby acknowledge that I received a copy of the "Joint Notice of Privacy Practices" from School Health LINK Inc. dated September 23, 2013.

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Patient Consent for Treatment

Services at the clinic may include the following:

1. Complete physical exam (school or athletic)
2. Immunizations
3. Emergency services when parent cannot be reached
4. Treatment of conditions that may cause exclusion from school (ringworm, impetigo, headache, dysmenorrhea, etc.)
5. On-site simple lab tests (lead, hemoglobin, pregnancy, UA, blood sugar)
6. Referral to local laboratory for more complex testing
7. Nutritional counseling
8. Individual and/or group health education services
9. Individual or family counseling and referral to appropriate agencies as needed
10. Chemical dependency counseling, referrals and services
11. Counseling and treatment of sexually transmitted disease, gynecological services
12. Dental referrals as needed
13. Release to/obtain from school: immunization/vision and hearing/lead level/appointment dates and copy of Certificate of Child Health Examination
14. Correspondence via US mail may be used

The aforementioned child has my consent to receive services, health care treatment, and diagnostic procedures provided by the **School Health LINK Inc.,** it's associated physicians, advanced providers, and other personnel. All questions and/or concerns have been addressed and explained to my satisfaction. I understand that although I am encouraged to be present for appointments, it is not required, and that by signing below, I am authorizing the **School Health LINK Inc.** to provide services to my child in his/her best interest. I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. I understand that if my child is 12 or older and were to receive mental health services at the **School Health LINK Inc.,** he/she may receive up to eight therapy sessions without my consent. I understand that follow-up may be needed if any tests indicate further treatment. Appropriate records pertaining to this patient will be forwarded to the family physician upon request. I understand the implications of giving consent to medical care through the **School Health LINK Inc.** The parent/guardian/student has the right to refuse services.

I hereby release and hold harmless the **School Health LINK Inc.** and their sponsoring agents and employees, (UnityPoint Medical Center, Genesis Medical Center, Rock Island County Health Department, IDPH, Rock Island/Milan Schools, Moline Schools, and East Moline Schools) from any and all liability for acting in conformance with this consent and in a manner consistent with the reasonable standards of care in the community under these circumstances.

I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to the patient, treatment and health care operations consistent with the **School Health LINK Inc.** I authorize payment of medical benefits to the **School Health LINK Inc.** or their designee for services rendered.

Patient or Legal Guardian Signature:_____ **Date:**_____

Staff/Witness Signature:_____ **Date:**_____

For Staff Use Only:

Check if any of the following apply:

☐ Parent or Guardian of minor with power to make health care decisions

I attempted to obtain an Acknowledgement of the Receipt of the Notice of Privacy Practices on behalf of School Health LINK Inc. The School Health LINK Inc. was unable to obtain the Acknowledgement because:

☐ Client refused to sign

☐ Other (specify) _____