SMART STUDENT HEALTH
SCHOOL HEALTH MODEL FOR ACADEMICS REACHING ALL TRANSFORMING LIVES

HEARTLAND HEALTH CENTERS
SCHOOL BASED HEALTH CENTER ENROLLMENT AND CONSENT FORM

HEARTLAND HEALTH CENTERS
HEALTHCARE FROM THE HEART

STUDENT INFORMATION **Student ID:**_____

Name of Student/Minor:_____ **Birthdate:**_____ **Sex: M- F- U**

Student Phone Number:_____ **Student Email:**_____

Address:_____ **Apt:**_____ **Zipcode:**_____

Race: (Circle all that apply) American Indian/Alaskan Native Black/African American Asian White Hispanic/Latino

Name(s) of Parent(s)/Legal Guardian:_____**Relationship:**_____

Telephone: Cell ( )_____ **Work ( )**_____ **Home: ( )**_____

Emergency Contact Name:_____ **Relationship:**_____

Emergency Contact: Cell ( )_____ **Work ( )**_____ **Home ( )**_____

Pharmacy Name:_____ **Pharmacy Telephone Number ( )**_____

Primary Care Physician:_____**Primary Physician Tel Number: ( )**_____

Preferred Language: PARENT - English Spanish Other:_____ **STUDENT- English Spanish Other:**_____

IF THE STUDENT HAS A SOCIAL SECURITY NUMBER PLEASE PROVIDE THE NUMBER:_____

DO YOU HAVE HEALTH INSURANCE? **___Yes ___*No If YES, Please complete the following:**

____AllKids/Medicad Recipient ID#_____**Insurance Company:**_____

____Private Insurance Recipient ID#_____ **Insurance Company:**_____

Parent/Legal Guardian Consent:

I authorize and consent to the enrollment of the above-named minor, of whom I am the parent or guardian. My consent will allow the qualified professional staff of Heartland Health Centers (HHC) and/or Alternatives, Inc.to provide in person comprehensive medical, dental and counseling services (if offered at my child's school health center) to my son/daughter, I also consent to the use of telemedicine, either interactive audio alone, or with video, to conduct medical counseling visits, if the clinic provider feels it is best for me child's health and safety. This consent is valid for the duration of the above named minor's attendance at_____School. I understand that no medical experiments will be conducted on my child, and that I may withdraw my consent by notifying the Health Center, in writing.

Comprehensive medical & dental care includes the same services my child could receive in a doctor's or dentist's office or clinic. Such services may include, but are not limited to:

- School and sports physicals, first aid for minor injuries, treatment of acute medical problems such as: sore throats, colds, stomach problems, and treatment of chronic medical problems such as asthma and diabetes.
- All CDC recommended immunizations. Vaccine Information Statements (VIS) for immunizations your child may require are attached. They may also be viewed at the following websites www. Heartlandhealthcenters.org/our-services/student-health
- Health education and promotion, nutritional counseling, reproductive health services.
- Counseling services include support that a social worker/counselor would provide the student related to classroom difficulties, substance abuse, and/or other adolescent development issues.
- Outpatient psychiatric care (not available at all sites)
- Laboratory services such as: blood or urine samples.
- Dental services (not available at all sites) may include, but are not limited to: routine or emergency exams, x-rays, cleaning, fluoride treatment, and sealants. Separate consent must be obtained for treatment plans including treating cavities, extraction of un-restorable teeth, etc

I understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care services. In addition, I understand that the Health Center staff may request additional forms with regard to certain types of treatment or procedures for my child. I understand my child may consent to certain types of services, and that confidentiality between the student and the Health Center professionals will be ensured in specific areas designated by Illinois law, and will not be discussed with the parent/guardian unless the student agrees. I further understand that the medical records maintained by the Health Center are confidential.

I authorize the school to release medical and school records to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and to my health care provider to assist in the care for my child. I also authorize my child's other health care providers to release information to the School Based Health Center staff members as needed. I understand that HHC's Notice of Privacy Practices is available to me on the HHC website, www.Heartlandhealthcenters.org, or I can request and obtain a printed copy at the health center.

Signature of Parent or Guardian **Date:**_____

Print Name of Parent or Guardian **Date:**

We follow the recommendations of the US Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics and strongly recommend annual flu vaccination. As part of our services, your child will be offered the flu vaccine every fall. If you do NOT want your child to receive the flu vaccine, check this box. ☐