UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE
AT ROCKFORD

PATIENT INFORMATION

☐ South Beloit School Based Health Center
☐ Blackhawk Park School Linked Health Center (Rockford)

Student's name _____ Grade _____ ID number _____

Today's date _____ ☐ Male ☐ Female Date of birth _____

Address _____
NUMBER STREET APT.

_____
CITY STATE ZIP CODE

Who does student live with? _____ Relationship _____

Who is responsible for any payments? _____

☐ Parent ☐ Guardian	☐ Parent ☐ Guardian
Name _____	Name _____
Phone: Home (_____) _____	Phone: Home (_____) _____
Cell (_____) _____	Cell (_____) _____
Employer _____	Employer _____
Work Phone (_____) _____	Work Phone (_____) _____
Email address _____ *For updates and news information*	Email address _____ *For updates and news information*

Emergency contact _____ Relationship to student _____

Phone: Home _____ Cell _____ Other _____

Race
- ☐ American Indian/Alaskan
- ☐ Asian
- ☐ Black
- ☐ Caucasian
- ☐ Declined
- ☐ Native Hawaiian/Pacific Islander
- ☐ Mixed Race
- ☐ Other _____

Ethnicity
- ☐ Declined
- ☐ Hispanic or Latino
- ☐ Non Hispanic or Latino
- ☐ Unavailable

Complete the following information regarding your child's medical coverage.

☐ No insurance ☐ All Kids ☐ Medicaid ☐ Medicaid HMO Recipient ID# _____

☐ Private health insurance (name of insurance company) _____

Name of employer _____

Policy number _____ Group number _____

Address of insurance company _____

Phone number of insurance company _____

Parent/guardian marital status: ☐ Single ☐ Married ☐ Divorced

Family housing (Rent, own, etc.): _____

Family preferred language: ☐ English ☐ Spanish ☐ Other _____

ELIGIBILITY

☐ Student attending school
Name of school

_____

Grade _____

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PARENTAL / GUARDIAN CONSENT FORM FOR HEALTH SERVICES

☐ South Beloit School Based Health Center
☐ Blackhawk Park School Linked Health Center (Rockford)

Student's name_____Grade _____ ID number_____

Today's date _____ ☐ Male ☐ Female Date of birth _____

PARENT CONSENT

The above-named student has my consent to receive services offered by
- ☐ South Beloit School Based Health Center
- ☐ Blackhawk Park School Linked Health Center (Rockford)

I have been informed of and understand the scope of services available to the student.

- Well child visits
- School and sports physicals
- Health screenings and immunizations
- Lab tests
- Treatment for minor illness and injuries
- Medication management
- Contraceptive care (with parental consent)
- Assistance and treatment with all health concerns
- Guidance and counseling:
  - Mental health
  - Risk-taking behaviors
  - Family planning
- We also assist with:
  - Insurance applications
  - Referrals for special needs
  - Coordination of care with a primary care provider
  - Translation services

I also understand that the school-based health center medical providers are employees of the University of Illinois College of Medicine at Rockford, Rockford, Illinois. I further understand the mental health professionals are representatives of a separate agency.

I understand school district personnel may become aware of my child's participation in these services. The content of services however, remains as confidential information, unless I execute an explicit consent authorizing the transfer/sharing of treatment information between the health center and school district personnel. I further understand that confidentiality between the student and the health center professionals will be assured in specific areas designated by the Illinois Consent and Confidentiality law and will not be discussed with the parent/guardian unless the student agrees.

I also consent to the transfer/sharing of information between the health center and school district personnel in order to facilitate evaluation of my child's health needs including emergency services, academic records, immunization records, results from hearing and vision screening and physical examination results. I further authorize the 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 federal and state laws and regulations regarding confidentiality. I understand that this consent will be honored while my child is a registered student. I understand that this consent may only be revoked through written authorization from parent or legal guardian.

A photocopy of this consent is valid as the original.

Notice of Privacy Practices

☐ I have received the Notice of Privacy Practices.

☐ I have been offered the Notice of Privacy Practices and decline to accept.

Signature of parent/guardian _____Date _____

Printed name of parent/guardian_____

Under Illinois Code, a minor 12 years of age or older has the same capacity as an adult to consent to certain health services and no parental permission is required for such services. These services include diagnosis and treatment of sexually transmitted infections, family planning, medical and health services related to substance abuse, mental illness and emotional disturbances.