Tapestry 360 Health Centers

School Based Health Center Enrollment and Consent Form

Student Data **Student ID#_____**

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

Student Phone Number: _____ Student Email:_____

Address:_____ Apt#_____ Zip Code:_____

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

PREFERRED LANGUAGE: Student: English/Spanish/Other: _____ **Parent:** English/Spanish/Other: _____

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

Phone Numbers: Home_____ Cell:_____ Work:_____

Pharmacy Name:_____ Pharmacy Phone Number:_____

Primary Care Physician:_____ Primary Care Phone Number:_____

Emergency Contact:

Name: _____Relationship to Student:_____ Cell #:_____

If the student has a Social Security number, please provide: _____

Do you have **Health Insurance**? __Yes __No If yes, please complete the following:
All Kids/Medicaid____ ID#_____
Private Insurance: ___ HMO ___PPO Name of Insurance Company: _____ ID#: _____

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 Tapestry 360 Health Centers (T3H) to provide in person comprehensive medical, dental, and counseling services (if offered at my child's school health center) to my son/daughter. When school is in session and the clinic is seeing patients on site, this care will be rendered at the clinic in the school my child attends. If the school clinic is closed, or I choose to bring my child to a community clinic, I understand that this consent allows care to be delivered at one of T3H's community clinic or at another other school-based clinic. If my child is in high school, he/she may be seen in a community clinic for care without a parent/guardian being present (just as they are seen in the school-based clinic without the presence of parent/guardian). I also consent to the use of telemedicine, either interactive audio alone, or with video, to conduct medical or counseling visits, if the clinic provider feels it is best for my child's health and safety**.** This consent is valid for the duration of the above-named minor's attendance at_____School, including summer and holidays when the school may be closed, but the clinic is open. 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.
- 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 the Health Center staff may request additional forms regarding 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 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 T3H Notice of Privacy Practices is available to me and I can request and obtain a printed copy at the health center.

Signature of Parent or Guardian **Date:**

Print Name of Parent or Guardian Rev 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 <u>NOT</u> want your child to receive the flu vaccine, check this box. ☐