Kankakee School District 111 School-Based Health Centers

REQUEST &AUTHORIZATION FOR TREATMENT, LABORATORY PROCEDURES, & MEDICAL EXAM

Date_____ Student's name_____ Birthdate_____ID_____
Sex:☐M☐F Race_____Ethnicity _____Current school _____grade_____
Parent/Guardian names_____
Home Address_____Home phone#_____
Student's SS #_____
Emergency contact_____phone#_____relationship_____

Below is a list of the services offered and rendered by the Health Center.

- Acute and chronic illness management
- Age -appropriate anticipatory guidance and screening
- Complete physical exam (annual, school, or athletic)
- Dental care
- Family, group, individual counseling
- First–aid and emergency services
- Immunization administration and reciprocation of immunization data with health departments, clinics, school nurses, and physician offices
- Individual and group health education programs
- Nutritional counseling
- Phlebotomy for lab analysis, and simple on-site laboratory testing (anemia, pregnancy, urine dipstick, blood sugar)
- Prenatal and postnatal counseling
- Providing copy of physical exam to school nurse and/or athletic department for school/sport participation
- Testing, treating, counseling, and referrals for sexually transmitted diseases
- Treatment of conditions that would cause absence or exclusion from school (headache, cramps, ringworm, lice, etc)

Unless otherwise noted, my signature below makes my child eligible for all services offered by the school-based health center.

The above named student has my consent to receive services offered by the School- Based Health Center. I have been informed of and understand the scope of services to be provided to my child.

****Please complete the following information and provide a copy of appropriate card****

Name of student's physician: _____

If you have **MEDICAL COVERAGE**, please complete the following information:

☐ **Kidcare** ☐ **Medicaid Recipient ID #**_____ ☐ **NO MEDICAL INSURANCE COVERAGE**

Private Health Insurance or HMO ☐ yes ☐ no **Ins.Co. name**_____

If yes, **name of insured** (i.e. parent/guardian)_____ **Employer name**_____

SS# / ID of insured_____**Policy #**_____**Group#**_____

Address of Ins Co. or HMO_____ Ins. Co. phone #_____

Is student enrolled in the Free or Reduced Lunch Program? ☐ Yes ☐ No

I (We) understand that the Health Center cannot guarantee the effectiveness of any treatment prescribed for _____,and I (We) have acknowledged that I (We) have received no such guarantee. I (We) may be contacted at _____ (or)_____if there are questions.

I also consent to the release of relevant health information to the Health Center in order to facilitate evaluation of my child's health needs. 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. By signing I also acknowledge receipt of the *Notice of privacy practices* of the Health Center, providing information about how we may use and disclose your protected health information per the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

The Health Center is proud to offer many internal referrals. These may include referrals for individual or group health education such as nutrition & weight management, wellness, disease prevention, exercise, yoga, and dental services. Referrals to our clinic social worker may include individual, group, and family counseling. The Health Center also makes many external referrals for services that the Health Center is unable to provide. These include referrals to other medical (ear, eye, nose, and throat, orthopedics, etc.), and dental (endodontists and oral surgeons etc.) providers and specialists. Referrals for additional abstinence education, sexual information, sexual health information, as well as family planning and related topics are made to private medical providers or New Life Center. Referrals are also made to mental health and/or substance use programs. The Health Center networks with many community agencies to provide these services. **Parents, please note that while the Health Center does *not* provide family planning services, Illinois State law makes these and other services available to those aged twelve and over *with or without* parental consent. The Health Center encourages parents to discuss these health needs with their child. The confidentiality between the student and the Health Center professionals will be ensured in specific areas designated by the law and will not be discussed with the parent/guardian unless the student agrees.**

Revised (3/19/04)

RELEASE AND INDEMNIFICATION

In consideration of Kankakee School District #111 honoring this request for examination and treatment, I (We) do hereby, for myself (ourselves) and (our) heirs, executors, and administrators, remise, release, and forever discharge Kankakee School District #111, all the members of its Board of Education, and all its administrators, officers, agents, and employees, and each of them, acting officially or otherwise from any and all claims, demands, actions, or causes of action whatsoever, arising out of or related to any loss, damage, or injury, including death, that may be sustained by myself (ourselves), _____ or our respective heirs, executors and administrators as a
(Child's name)
result of the examination and treatment of _____ as hereby requested and authorized.
(Child's name)

In addition, in consideration of Kankakee School District #111 honoring this request for administration of medication, I (We) do hereby agree to indemnify and save harmless Kankakee School District #111, all the members of its Board of Education, and all its administrators, officers, agents and employees, and each of them acting officially of otherwise, against any and all liability, loss, damages, costs, and expenses (including reasonable attorneys' fees) which the said Kankakee School District #111, or all the members of its Board of Education, or its administrators, officers, agents and employees, or any of them, may hereafter suffer, incur, be put to, pay, or lay out to _____ or to any other person,
(Child's name)

firm, corporation, or governmental agency arising out of, directly or indirectly, the examination and treatment of _____ as hereby requested and authorized.
(child's name)

In WITNESS WHEREOF, I (We) have signed the Request and Authorization for Treatment, Laboratory Procedures and Medical Exam and Indemnification on the ____ day of _____ 2____.

_____
Parent/guardian signature

_____
Witness signature (Health center)

REVISED 03/07/95