LakeCounty
Health Department and
Community Health Center

Round Lake Area Student Health and Wellness Center and TB Clinic Consents

Consent for TB screening and testing:
I (the parent) consent to Tuberculosis screening and recommended testing services for my child _____ (Student First/Last Name) _____ (Date of Birth) by the Lake County Health Department and Community Health Center TB clinic program and/or the Round Lake Area Student Health and Wellness Center.

Signature of Parent/Guardian: X_____ **Date:** _____

Signature of Patient: X_____ **Date:**_____

Consent for Care:
I, for myself or the patient, _____ (Student First/Last Name) _____(Date of Birth), hereby consent to receive the services offered by Lake County Health Department and Community Health Center at the Round Lake Area Student Health and Wellness Center at Round lake High School. I understand that physicians, nurses and other health care providers in training may, under the supervision of appropriate personnel, participate in the treatment and I consent to such student involvement in care.

All students under the age of 18 are eligible for services if they have obtained written parental consent or if they are otherwise permitted under Illinois law to consent on their own behalf to such care. In addition, a parent, legal guardian, or student who is permitted under Illinois law to consent on his/her own behalf has a right to refuse any health care services.

I have read the above information and have had the opportunity to have my questions answered. I understand that I may revoke this consent at any time[1]. I do hereby give my consent for my child to receive services offered by the Student Health and Wellness Center, except for those services excluded above.

Release of Information:
I give permission to the Lake County Health Department and Community Health Center programs including the TB clinic program, to exchange protected medical information between the Student Health and Wellness Center and the appropriate Round Lake School District 116 personnel. This authorization shall remain in effect through the student's enrollment unless revoked. This release *does not* include releasing privileged information concerning treatment for drug and alcohol use, sexually transmitted infection information or HIV status. An additional release will be required for these services.

Authorization for Release of Information for Payment:

[1] Illinois State law requires a parent's or legal guardian's consent to provide medical treatment to a minor child except for family planning, sexually transmitted infection services, and certain mental health services when the minor is 12 years of age or older (Consent by Minors to Medical Procedures Act).

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Services will be billed to Medicaid, Medicare or other third-party payer. We do charge a usual and customary fee for services. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. Your insurance policy is a contract between you and your insurance company. No one will be refused services because of an inability to pay.

I authorize the Lake County Health Department and Community Health Services to release and/or send any medical information necessary for the processing and payment of my medical bills to any insurance company or third-party payer who may be responsible for paying any part of my medical treatment. This includes release to my employer for employment related injuries under worker's compensation claim. We will make every effort to ensure confidentiality in all transactions.

I, the undersigned, also give my consent to the Lake County Health Department and Community Health Center to release all information necessary, including my name, date of birth and Social Security Number (SSN), family income and number of dependents, to the Illinois Department of Human Services (IDHS) and the Illinois Department of Healthcare and Family Services, in order to establish my eligibility for funding for my treatment. I understand that the release of my SSN is voluntary. Failure to provide my SSN may jeopardize funding for my treatment from state agencies and may make me responsible for payment for treatment. If I am required to provide toxicology testing as part of my care, I understand that my SSN may be used to report the results to IDHS.

Acknowledgement of Receipt of Notice of Privacy Practices:
My signature on this form acknowledges that I have received a copy of Lake County Health Department and Community Health Center Round Lake Area Student Health and Wellness Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the Lake County Health Department and Community Health Center's Student Health and Wellness Center and TB program and my rights with respect to my health information. I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

I have read the above information and have had the opportunity to have my questions answered. I do hereby give consent and permission to the above

Signature of Parent/Guardian: X _____ **Date:**_____

Signature of Patient: X _____ **Date:**_____

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PATIENT INFORMATION		
Full Name:		Sex: M___ F___
Date of Birth:	Grade:	Classroom:
Primary Language: ____English ____Spanish _____Other (Specify_____)		
Military Status: ____Veteran ___Non-Veteran		
Ethnicity: ___Hispanic or Latino ___Not Hispanic or Latino ___Prefer Not to Answer		
Race: Which category best describes your race? ___Asian ___Black or African American (including Black/African-American of Latino/Hispanic descent) ___American Indian/Alaska Native (including Amer. Indian/Alaska Native of Latino/Hispanic descent) ___White (including Whites of Latino/Hispanic descent) ___More than one race ___Unreported ___Prefer not to answer		
Housing Status: ___Own/Rent ___Homeless Shelter ___Doubling Up (living with family or friend) ___Prefer not to answer ___Other		
Street Address (including city/state):		Apt #

PARENT/GUARDIAN CONTACT INFORMATION	
Name:	Date of Birth:
Relationship: ___Parent ___Legal Guardian (not parent) ___Grandparent ____Other (Specify _____)	
Street Address (including city/state):	Apt #
E-mail:	
Primary Phone: _____ Ok to text? ___Yes ___No	Secondary Phone:_____ Ok to text ___Yes ___No

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EMERGENCY CONTACT INFORMATION	
Same as Above ___Yes ____No	If no, complete below:
Name:	
Relationship: ___Parent ___Legal Guardian ___Grandparent ____Other (_____)	
Primary Phone: Ok to text? ___Yes ___No	Secondary Phone: ___Yes ___No
Insurance/Provider Information	
Insurance Type: _____Private _____All-Kids ____None	
All-Kids Case ID#	All-Kids Recipient ID#
Private Insurance – Name of Company:	
Policy or ID#	Group #
Name of Policy Holder:	
Policy Holder DOB:	Family Size:
Does your child have a regular primary health care provider? ___Yes ___No	
If yes, what is the name of the doctor?	

Patient Label