

HEARTLAND INTERNATIONAL HEALTH CENTER
ENROLLMENT AND CONSENT FORM

Student Data

Div # _____ ID # _____

Name of Minor: _____ Sex: M F Birthdate: _____

Address: _____ Zip: _____ Tel: () _____

Race: (Please circle one) American Indian/Alaskan Native, Black Hispanic/Latino, Black Non-Hispanic/Latino, Mixed Race, White Hispanic/Latino, White Non-Hispanic/Latino, Asian.

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

Tel: Home: () _____ Cell: () _____ Work: () _____

Emergency _____ **Relationship:** _____

Contact: Tel: () _____ Cell: () _____ Work: () _____

Preferred Language: English Spanish Other (specify): _____

DOES THE STUDENT HAVE A SOCIAL SECURITY NUMBER? _____ **YES** _____ **NO**

If so, please provide the number ____ - ____ - ____

DO YOU HAVE HEALTH INSURANCE? _____ **YES** _____ **NO**

If you do, please complete the following:

State Insurance: _____ AllKids _____ Medicaid _____ HMO Recipient ID#: _____

Private Health Insurance: _____ HMO _____ PPO Name of Insurance Company: _____

Name of Insured (i.e. parent/guardian): _____

S.S. #: _____ - _____ - _____ Policy #: _____ Group #: _____

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 International Health Center and Alternatives, Inc. to provide comprehensive medical, dental and counseling services to my son/daughter, including health care services, should they become ill during their attendance at school. 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 person.

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
- Immunizations
- First aid for minor injuries
- Treatment of acute medical problems, such as: sore throats, cold, stomach problems,
- Health education and promotion
- Diagnosis and treatment of illnesses such as: diabetes, high blood pressure, etc.
- 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.
- Nutritional counseling
- Reproductive health services
- Laboratory services, such as: blood or urine samples
- Dental services may include, but are not limited to: routine or emergency examinations, x-rays, cleaning teeth, treating caries (cavities), extraction of un-restorable teeth and on-going care of existing dental conditions such as gingivitis, etc.

I understand that the Health Center staff may request that I sign 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 understand that the professional staff at the Health Center may encourage the practice of abstinence (not having sex) in their discussions with the Health Center patients. I further understand that the medical records maintained by the Health Center are confidential.

I hereby authorize the Chicago Public Schools to release the records of previous physicals and immunizations pertaining to my child for use by the health professionals at the Health Center. I understand that I must notify the Health Center in the event my address or telephone number changes.

Signature of Parent or Guardian

Date