Loyola University Chicago Marcella Niehoff School of Nursing
School-Based Health Center (SBHC) at Proviso East High School PH: 708-668-9067
LoyolaSBHC@pths209.org

Registration and Consent Form

Student Information:

Name: _____ PEHS ID#_____

Date of Birth: _____/_____/_____ Gender: _____ Male _____ Female _____ Other

Address: _____

Apt#_____ City: _____ Zip Code: _____

Student's Cell Phone: _____

Race/Ethnicity (Check ALL that apply) ☐ African American/Black ☐ American Indian/Alaskan Native

☐ Asian ☐ Cuban ☐ Hawaiian/Pacific Islander ☐ Mexican/Mexican American/Chicando

☐ Puerto Rican ☐ Another Hispanic/Latino(a) ☐ White ☐ Prefer not to answer ☐ Unknown ☐ Other:

Parent/Legal Guardian

Name of Parent/Guardian: _____ Relationship: _____
(Mother, Father, Legal Guardian)

Home Phone: _____ Work phone: _____

Cell Phone: _____

Emergency Contact Information:

Name of Emergency Contact: _____ Relationship: _____
(Parent/Legal Guardian/Relative)

Phone Number: _____ Cell Number:_____

Student's Primary Care Provider: _____ Provider's Phone Number: _____

Does student have any allergies? (food, medicine, other)

_____

Medication(s) student takes:

_____

Does student have any type of Health Insurance? (Check all that apply)

_____ Medicaid _____ AllKids _____ No health insurance

_____ Private Insurance: _____
(Name of Insurance Carrier)

- **Please bring copy of your Medicaid, All Kids, or Insurance Card for our records. We need to make a copy of your child's insurance card as we may bill Medicaid or your insurance for selected services. However, no registered student will be denied services based on insurance status.**

If you do not have health insurance for your student, the SBHC will provide information on the Affordable Care Act and All Kids Program. Information for All Kids can be found at hfs.illinois.gov/medicalprograms/allkids/about and at (866) ALL-KIDS or (866) 255-5437.

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Enrolled students may receive health care regardless of insurance status or ability to pay.

Consent for Healthcare Services and Disclosure of Medical Information:

I, the Student/Patient, agree to the following:

I, the Parent/Guardian/Legal Representative agree to the following on behalf of myself and the Student/Patient:

1. Scope of Available Services. I have read the brochure information for the School-Based Health Center, which is operated by Loyola University Chicago Marcella Niehoff School of Nursing, and located in Proviso East High School (the "SBHC") and have been informed of and understand the scope of the services offered to students by the SBHC. I have been informed that the SBHC Notice of Privacy Practices is available upon request.

2. Consent to Treat. I consent to health education, medical care and counseling services, diagnostic procedures, treatment and administration of medications deemed necessary and appropriate to treat the Student/Patient's condition or illness at the SBHC. I consent to the administration of immunizations to the Student/Patient as recommended by the CDC adolescent immunization schedule, including, but not limited to, vaccinations for tetanus, diphtheria and pertussis, meningococcal and human papilloma virus. I understand, consent and agree that (a) treatment and services will be provided by physicians who are employees of Loyola University Medical Center ("LUMC"), as well as Nurse Practitioners, Social Workers, Nutritionists and support staff who are employees of Loyola University Chicago; (b) Loyola University Chicago medical, nursing, social work and dietetic students in training may, under the supervision of appropriate personnel, participate in my treatment and care; (c) laboratory services may be provided by LUMC; and (d) electronic medical record services for the SBHC will be provided by LUMC, and information in the Student/Patient's electronic medical record at the SBHC will also be shared with health care providers in the Loyola University Health System and its affiliates. I understand that I may revoke my consent at any time and that services for the Student/Patient are voluntary and not mandatory.

3. Use and Disclosure of Patient Information. I understand, consent and agree that the SBHC and LUMC may receive, use and disclose information concerning the Student/Patient's care, prescription medications and health care coverage for evaluation, treatment, payment and health care operations purposes including but not limited to the disclosures described in each of their Notices of Privacy Practices (available upon request) and to medical, nursing and insurance providers in order to facilitate the Student/Patient's healthcare. I consent to the release and transmission of the Student/Patient's immunization records for electronic storage in the I-Care/Illinois State Immunization Registry unless I indicate in writing that I do not want these immunization records in the registry. I grant the SBHC permission to give my child's school physical and immunization records to the school nurse. I grant the SBHC permission to give my child's sports physical to the athletic department.

4. Confidentiality Provisions for the Student/Patient.

(a) I understand that the confidentiality between the Student/Patient and the SBHC professionals described above will be maintained for specific health conditions and procedures when authorized by minors consent laws in the state of Illinois, and in those situations, information about the Student/Patient will not be given to or discussed with the Parent/Guardian unless the Student/Patient agrees. This means we will not talk about the Student/Patient to his or her Parents/Guardian, unless we are given the permission to do so, or unless required by law.

(b) Except for Parents/Guardians, or as allowed in the "Use and Disclosure of Patient Information" section described above, or in the Notice of Privacy Practices, or in the "Assignment of Benefits" section below, information about the Student/Patient will not be given to anyone outside of the SBHC and LUMC and its affiliates unless given the permission to do so, or as required by law. This means we will not talk about the Student/Patient to his or her teachers, police, or anyone else unless we are given the permission to do so, or unless required by law.

(c) The following are a few examples of additional exceptions in which we will have to talk to specific adults in order to protect the Student/Patient. We MAY have to tell someone if:

1) An injury or accident happens on school property;
2) You tell us that you are being physically or sexually abused;
3) You have done harm or could do harm to yourself or someone else; or
4) You have a life-threatening condition.

Please sign next page ⇨

Except for the exceptions listed above, the SBHC staff will make every effort to talk with the Student/Patient first before we talk to anyone else.

(d) Just as the staff of the School-Based Health Center agrees to protect my confidentiality, I, the student/patient, agree to respect the confidentiality of all other students/patients that I may see in the SBHC. This means that if I see another student/patient in the SBHC and/or I hear information about someone that may be personal, I agree to keep that information to myself and tell no one else.

5. SBHC Telehealth Services

What are telehealth services/virtual School-Based Health Center visits? Telehealth services refer to counseling sessions or medical visits that occur via telephone, text, or videoconference via a smart phone, tablet or computer. Telehealth visits may be offered as an alternative or supplement to face-to-face health care visits.

Benefits of telehealth visit: Telehealth services may be offered to improve access to counseling and primary care visits when face-to-face counseling and medical visits are not possible, such as during the COVID-19 public health emergency. Telehealth visits may also be offered because they increase access to care for patients and/or families who may not be able to access face-to-face visits due to a variety of circumstances.

Risks of telehealth visits: The efficacy of telehealth visits may be different than that of in-person services, and the results of telehealth services cannot be guaranteed or assured. You and your medical or behavioral health provider will decide what care can be delivered via telehealth and what care is not appropriate for telehealth. Telehealth visits may not be the best choice or an appropriate means of providing service for a number of reasons including, but not limited to: persons experiencing an emergency medical condition requiring emergency in-person evaluation and treatment; patients presenting a heightened risk of harm to oneself or others; the need for an in-person physical assessment to diagnose or treat a medical problem; or the need for more intensive, personal services. In such cases, your SBHC provider will help you establish referrals to the appropriate services.

A. Other potential risks of telehealth services include the risk of diminished privacy and the possible disclosure of confidential information. The Loyola University Chicago SBHC provider or Loyola University Health System/Trinity Health provider will not make video, audio or photo recordings of your telehealth visit. However, be aware that the operator of the videoconference platform used for telehealth visits may be able to hear, observe or have a back-up copy of communications between you and the provider.

B. It is also possible that a patient participating in a telehealth visit may be heard or observed by persons in the setting they are in during the telehealth visit. It is the responsibility of the patient to maintain whatever level of privacy they desire during the visit.

Alternatives to telehealth visits

You do not have to agree to a telehealth visit. You and your medical or behavioral health provider can decide alternatives to telehealth visits.

6. Assignment of Benefits. In consideration for and in the event that the SBHC is able to bill for any health care services rendered, I hereby assign any insurance, health plan, Medicaid or third party benefits otherwise payable to me or on my behalf to, and authorize direct payment to, LOYOLA UNIVERSITY CHICAGO. I authorize any holder of medical or other information about me to release to applicable payors, agencies and their agents any information needed for processing claims for payment of such benefits.

Signature of Parent/Legal Guardian: _____ Date: _____

Relationship to Student: _____
(Mother, Father, Relative, Guardian, etc.)

I have read the consent form and give my assent/consent to the School-based Health Center and staff from Loyola University Chicago and Loyola University Medical Center to provide me with health services and counseling. I understand that I may revoke my assent/consent at any time and that services for me are voluntary and not mandatory.

Signature of Student: _____ Date: _____

Please SAVE and EMAIL completed form to LoyolaSBHC@pths209.org.

Loyola School-Based Health Center at Proviso East High School | 807 South First Ave., Maywood, IL 60153 Phone: 708-668-9067 | email: LoyolaSBHC@pths209.org

Vaccine Information Sheets

Hepatitis A

Hepatitis B

Human papillomavirus

Influenza

Meningococcal ACWY

Meningococcal B

MMR (Measles, Mumps, Rubella)

Polio

Tdap, English (Tetanus, Diphtheria, and Pertussis)

Varicella