



School ID #: _____

Date: _____

Student/Patient Information: Student at: _____ Grade: _____

Name: _____ Birthdate: _____ Male Female

Race: Asian/Pacific Islander Black/African American White Native American/Aleutian
 More than one race Other: _____ Decline to Report

Ethnicity: Hispanic Non-Hispanic Decline to Report

Address: _____
Street City State Zip

Parent/Guardian: _____ Home Phone #: () _____
Name

Work Phone #: () _____ Employer: _____

Preferred Language: English Spanish Other: _____

Marital Status: Single Married Divorced

Emergency Contact: _____
Name Relationship to Student

Home Phone #: () _____ Work Phone #: () _____

Doctor or Clinic: _____ Phone #: () _____

Medical Coverage:

Medicaid/Blue Cross Community Medicaid/Meridian Medicaid/IlliniCare
 Medicaid/Other: _____ ID#: _____
 Private Insurance: (circle one) HMO or PPO Date of Birth (Parent/Guardian): _____
Name of Insured (i.e. parent/guardian): _____
Social Security Number/ID of Insured: _____
Employer of Insured: _____
Policy Number: _____ Group Number: _____
Address and Phone Number of Insurance Company: _____

No medical coverage Weekly income for the household: \$ _____
Household Size (number of people supported by income): _____

Consent: I hereby give consent for the services offered at the VNA Health Center at East Aurora High School and/or the VNA Mobile Health Clinic. I have been informed and understand the scope of services to be provided. I further understand that confidentiality between the student/patient and Health Center professionals will be ensured in specific areas designated by law and will not be discussed with the parent/guardian unless the student agrees. I also understand that a parent, legal guardian, or student who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care service. I authorize exchange of school and sports physicals and immunization information between VNA Health Care and East Aurora School District 131. I acknowledge that other information, as permitted by law, may be exchanged between VNA Health Care and East Aurora School District 131. I authorize VNA Health Care to release information to third party payers for billing, program management and evaluation in accordance with federal and state laws and regulations regarding confidentiality. This authorization is valid until the individual turns 18 or until revoked by mailing a letter to: VNA Health Care, Attn: Medical Records, 400 N. Highland Ave, Aurora, IL 60506.

(Parent or Guardian for students under 18)

Date

(Students over 12 or Patient)

Date