VNA Health Care

Student Registration and Consent Form

Select your student's school district from those listed below:

- ☐ **Bensenville School District 2** (Including Blackhawk Middle School)
- ☐ **Community Consolidated School District 93** (Including Carol Stream Elementary School)
- ☐ **East Aurora School District 131** (Including East Aurora High School)
- ☐ **Elmhurst Community Unit School District 125** (Including York Community High School)
- ☐ **Fenton Community High School District 100**
- ☐ **Glenbard Township High School District 87**
- ☐ **Indian Prairie School District 204** (Including Metea Valley High School)
- ☐ **Joliet Public Schools District 86**
- ☐ **Joliet Township High School District 204** (Including Joliet West High School, Joliet Central High School)
- ☐ **School District U-46** (Including Elgin High School and South Elgin High School)
- ☐ **Valley View School District 365** (Including Romeoville High School and Bolingbrook High School)
- ☐ **West Aurora School District 129** (Including West Aurora High School)

Convenient Services for Students Include:

- School physicals and immunizations
- Sports physicals
- Acute illness and injury care (e.g. ear infections, sore throats, or sprained muscles)
- Chronic illness care (e.g. asthma, diabetes, or seizures)
- Reproductive health services (e.g. abstinence counseling, menstrual issues, pregnancy and STI tests)
- Nutrition and weight counseling
- Wellness exams and routine health screenings
- Lead screening, TB tests, and other laboratory services
- Smoking, vaping, alcohol and drug use prevention education
- Mental health services for stress, depression, emotional support and referrals

Student/Patient Information:

School Name:_____ School ID #:_____ Grade: _____

Name: _____ Date of Birth: _____

Gender (Check One): ☐ Male ☐ Female ☐ Intersex ☐ Transgender ☐ Other: _____

Race (Check One): ☐ 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: _____ City: _____ State: _____ Zip: _____

Parent/Guardian Name: _____ Home Phone #: _____

Work Phone #: _____ Employer: _____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐ Other:_____

Emergency Contact Name: _____ Relationship: _____

Home Phone #**:** _____ Work Phone #: _____

Doctor or Clinic: _____ Phone #: _____

Medical Coverage: To view in-network insurance plans, visit https://www.vnahealth.com/plans-insurance-accepted/

☐ Medicaid Plan Name: _____ Medicaid ID#: _____

☐ Private Insurance Plan: _____

Name of Insured (i.e. Parent/Guardian): _____

Date of Birth of Insured (Parent/Guardian):_____

Social Security Number/ID of Insured: _____

Employer of Insured: _____

Policy Number: _____ Group Number: _____

Insurance Phone #: _____

Insurance Address: _____

Insurance City: _____ State: _____ Zip: _____

☐ 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 by VNA Health Care 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 the school district designated at the beginning of this document. I acknowledge that other information, as permitted by law, may be exchanged between VNA Health Care and the school district designated at the beginning of this document. 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.

Consent Acknowledgment:

_____ _____ _____ _____

(Parent or Guardian for students under 18) Date (Students over 12 or Patient) Date