School-Based Health Center
Authorization to Treat a Minor Child

The SIHF Healthcare School-Based Program is a partnership with Collinsville Community Unit School District No. 10 (CCUSD) to provide primary healthcare services. By completing this form and consenting for services, you are granting permission for the evaluation and treatment of your child. In addition, you are granting permission for the release of necessary information by both SIHF Healthcare and CCUSD for the purpose of documenting compliance with state requirements and for the planning and delivery of quality healthcare (e.g. basic health history, immunization records, and school and sports physicals).

By completing this form, you authorize insurance payment of medical benefits to SIHF Healthcare and the release of personal/health information necessary to process insurance claims.

This consent authorization will remain valid and on file with SIHF Healthcare and the School-Based Program as long as your child is enrolled in the CCUSD. You reserve the right to revoke this authorization at any time.

Consent for treatment:
I hereby consent to the enrollment of my child in the School-Based Program for the medical treatment encompassing routine diagnostic treatment and medical treatment by the medical staff or their designee as determined necessary in their judgment for the welfare of my child. I understand that I may revoke this consent at any point by notifying SIHF Healthcare.

I give permission for the following services:
❒ Physical Exams (including Sports)
❒ Immunizations
❒ Assessment, diagnosis and treatment of minor illness and injury
❒ Laboratory tests

Parent/ Legal Guardian Authorization and Contact Information

Name: (print) _____

Phone (____) _____

Address_____

Signature_____ **Date** _____/_____/_____

Child's Name: _____DOB: ____/____/____

School's Name_____

Medical History

Allergies: *(please list)*
Medication/Drugs _____

Food _____

Other _____

Chronic Illness/Hospitalization or Surgery *(please list)*

_____

_____

Health Insurance
Medicaid Recipient ID# _____

Other Health Insurance
Plan Name_____ Policy Number_____

Primary Subscriber_____ Group # _____

Preferred Pharmacy
Name _____

Location_____