Madison School Based Health Center

School-Based Health Center

What is a school-based health center?

It is a unique health care model in which comprehensive physical, mental and preventative health services are provided to school-aged youth in the school setting.

How much does it cost?

Nothing! *There are* ***NO co-pays****. The clinic accepts the amount paid by insurance.*

What types of services are offered?

- Age appropriate well-child exams
- Diagnosis and treatment of acute illness and injury
- Management and monitoring of chronic health conditions
- Lab testing
- Immunizations
- Mental health referrals
- Nutritional services
- Allergy injections
- Sports physicals
- PPD testing

How do I enroll my child?

Call Madison School District at 618-877-1712. You may also download, complete and mail in the enrollment forms available below.

When is the clinic open?

During normal school hours---Monday through Friday. 8:30 AM to 4:30 PM

What if my child needs care at times the school-based clinic is not open?
You may take your child to the Gateway Medical Group located in Collinsville, IL during its hours of operation or the Gateway Regional Medical Center Hospital Emergency Department if the Gateway Medical Group is closed. (Please do not take your child to the ER for non-emergencies, if the Gateway Medical Group is open.)

Please note that while there is no charge for services obtained at the school-based health center, typical copays/fees apply for visits to the Gateway Medical Group and the Emergency Room.

MADISON SCHOOL BASED HEALTH CENTER
CONSENT FORM

Parent/Legal Guardian Consent for Care: ______________________________

I hereby request, authorize, and consent to the enrollment of my son/daughter in the Madison School-Based Health Center ("SBHC") to receive the services offered by the Madison SBHC. I understand that my signing this consent allows the health care provider/physician, nurses and other health care providers in training, under the supervision of appropriate personnel, to provide comprehensive health services to my son/daughter. This consent is valid for the duration of the above named minor's enrollment in the Madison SBHC site. I understand that I may withdraw my consent at any time.

All students under the age of 18 are eligible for services if they have obtained written parental consent or if they are otherwise permitted under Illinois law to consent on their own behalf to such care. In addition, a parent, legal guardian, or student who is permitted under Illinois law to consent on his/her own behalf has a right to refuse any health care services.

No medical experimentation or research will be conducted on my child at any time during my son/daughter's enrollment at Madison. Services provided include routine medical care, including acute and preventative, laboratory screens, STD screening and treatment, immunizations, pregnancy tests, reproductive health services, school and sports physicals, counseling, nutrition services, health education to promote healthy lifestyles, referrals to other needed services, and emergency care.

I understand that 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 further understand that the medical records obtained by the Health Center are confidential. I give consent for professional employees of Gateway Regional Medical Center to access my medication history and release my child's immunization and Certificate of Child Health Examination form to Madison School District. I give consent for the Madison SBHC to have access to my child's health records maintained by the Madison area schools. I give permission for the release of my child's records and health information to their physician. I authorize the release of information to insurers as necessary for payments of services rendered for my child directly to Gateway Medical Group.

I have read the above information and have had the opportunity to have my questions answered. I understand that I may revoke this consent at any time*. I do hereby give my consent for my child to receive services offered by the Madison School Based Health Center.

______________________	______________	( ) ______________
Signature of Parent/Guardian	Date	Area Code/Phone #

I understand that every effort will be made to contact me prior to services being provided, as required under Illinois law*. We encourage parents/guardians to call or visit if they have any questions.

*Illinois State law requires a parent's or legal guardian's consent to provide medical treatment to a minor child except for family planning, sexually transmitted infection services, and certain mental health service when the minor is 12 years of age or older. (Consent by Minors to Medical Procedures Act [410 ILCS 210/0.01, 4, 5 et seq.; 325 ILCS 10/0.01 et seq.)

Gateway Medical Group

SCHOOL BASED HEALTH CENTER

ENROLLMENT FORM

Student Name:	Grade:	DOB:	Sex: M F
Social Security #:	Race (Circle): White Black Asain Hispanic		Other:

PARENT OR GUARDIAN INFORMATION

Name:	Name:
Address:	Address:
City: State: Zip:	City: State: Zip:
Home Phone: County:	Home Phone: County:
Work Phone:	Work Phone:
Employer:	Employer:
Relationship to child: (Circle) Mother Father Guardian	Relationship to child: (Circle) Mother Father Guardian
Soc Sec # DOB:	Soc Sec # DOB:

Emergency Contact: Name & Phone: Relationship:

Does student have health insurance? Yes No

If yes, Please complete INSURANCE INFORMATION

Insurance name:	Policy Number:
Policy Holders name:	Group Number:
Medical Claims Aderss:	Insurance phone #:
Medicaid ID #:	
Meridian ID#	Attach a copy of front and back of insurance card
Molina ID #	
Harmony ID #	

Check One

_________ I would like to use the School Based Health Center for my Primary health care needs.

_________ My child regulary goes to another health care provider and I would like to use the SBHC when necessary

PHYSICIAN INFORMATION

Does you child have a Physician? Yes No

Physician Name: Address:

Phone: Date of Last visit: / / Reason:

PARENTAL CONSENT FOR TREATMENT AND RELEASE OF INFORMATION

I give consent for my child to receive services provided by the staff of the School Based Health Center. Also, I give consent for the School Based Health Center to have access to my child's health records maintained by Madison Area Schools. I give permission for the release of my child's records and health information to their physician. I authorize release of information to insurers as necessary for payments of services rendered for my child directly to Gateway Medical Group.

Signature of Parent or Guardian: ______________________ Date: __________

Please understand that every effort will be made to contact me prior to services being provided. The staff at the School Based Health Center believe that parental involvement is essential in keeping children healthy and will encourage each student to involve their parents in health care decisions. We encourage parents/guardians to call or visit if they have any questions.

Mail completed form to: "School-Based Health Center" at your local school's address.