Promise Healthcare

Minor Consent for Treatment

Minor's full name: _____Date of Birth: _____

A physician, nurse practitioner, physician assistant, dentist, dental hygienist, nurse, psychiatrist, and mental health counselor are available, as scheduled, to provide medical, dental, behavioral health, and nutritional services. Services may include but are not limited to:

- **Physical exams, health assessments, and screenings**
- **Acute and chronic illness/injury diagnosis and treatment**
- **Health education, promotion, and prevention workshops**
- **Immunizations**
- **Wellness services, including smoking cessation, nutrition, and weight management**
- **Reproductive health services, including gynecologic exams, STI/STD and HIV/AIDS education, testing, counseling, treatment, and contraceptive care**
- **Laboratory testing (e.g., throat cultures, CBCs, mono spot tests)**
- **Mental health counseling**
- **Dental examinations and treatment**
- **Referrals for services not available at the School-Based Health Center**

By signing below, I certify and affirm that:

The aforementioned child has my consent to receive services offered by Promise Healthcare by its providers. I have been informed of and understand the scope of services which may be provided. I also understand that a parent, legal guardian, or minor who is permitted under Illinois law to consent on his or her own behalf has a right to refuse any health care service(s). I also understand that although I am encouraged to be present for appointments, it is not required and that by signing below, I am authorizing Promise Healthcare to provide services to my child in his/her best interest.

I further understand that under Illinois law, a minor over age 12 has the same capacity as an adult to consent to certain health services and no parent is required for such services.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services from Promise Healthcare, he/she/they may receive up to eight therapy sessions without my consent. By law, a child under age 12 will not be allowed to receive mental health/substance abuse services without parental consent.

Optional Authorization to Share School Health Compliance Records

Initials_____ **YES, I authorize Promise Healthcare to share proof of my child's required Illinois school physicals, immunizations, and dental/vision exams directly with _____(Name of School District) nursing and administrative staff for purposes of** *(declining to check this box will not impact your child's eligibility to receive healthcare services at our clinic).*

This consent shall be effective from the date of signature for one year unless I terminate it in writing or at such time that the minor turns eighteen (18) or otherwise becomes emancipated.

Parent/guardian printed full name:_____ **Relationship to minor**:_____

If/when I am not available, I authorize the following person(s) to accompany this minor to their appointment(s) if applicable

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Parent/guardian signature:_____ Date:_____

Patient signature (12 years or older):_____ Date: _____

Forms committee approved 8.12.26