Minor Consent for Treatment

Minor's full name: _____ Date of birth: _____

A physician, nurse practitioner or physician assistant, dentist, dental hygienist, nurse, and mental health counselor are available, based on schedules, to provide primary health care, dental care, psychosocial services, and nutritional consultations.

Available services may include, but are not limited to:

- Physical examinations, health assessments, and/or screening for health problems
- Diagnosis and treatment of acute illness and injury
- Diagnosis and management of chronic illness
- Health education and promotion: outreach health promotion/prevention workshops will be offered
- Immunizations
- Wellness promotion including smoking cessation, nutrition, and/or weight management
- Reproductive health care including gynecological examinations, STD education, testing, and treatment, HIV/AIDS education, counseling/testing, and contraceptive services
- Laboratory tests including throat cultures, complete blood counts, mono spots, etc.
- Mental health counseling services
- Dental examination and treatment
- Referrals to other agencies for services not provided at the Urbana School Based Health Center (USBHC)

PARENTAL/GUARDIAN CONSENT

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 services. 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 parental permission is required for such services.

I understand that if my child is 12 or older and were to receive mental health/substance abuse services 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.

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 child to their appointment(s) *if applicable* (please state full name(s) and relationship to child):

_____

Parent/guardian signature: _____ Date: _____

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