

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

- Batavia School District 101**
- Bensenville School District 2** (Including Blackhawk Middle School)
- Community Consolidated School District 93** (Including Carol Stream Elementary School)
- DuPage High School District 88**
- East Aurora School District 131** (Including East Aurora High School)
- Elmhurst Community Unit School District 125** (Including York Community High School)
- Fairmont School District 89**
- 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)
- Salt Creek School District 48**
- 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)
- Villa Park School District 45**
- West Aurora School District 129** (Including West Aurora High School)
- West Chicago Elementary School District 33** (Including Leman Middle 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