Student Registration & Consent Form

VNA Health Center at the Jeff Craig Family Resource Center
For Students of West Aurora School District 129

Convenient services for students include, but are not limited to:

- 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. menstrual issues)
- Nutrition and healthy lifestyle counseling
- Wellness exams and routine health screenings
- Lead screening, TB tests, and other laboratory services
- Smoking, vaping, alcohol and drug use prevention education
- Mental and behavioral health services for ADHD, stress, depression, emotional support
- Referrals for vision, dental, family counseling, and other services

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

VNA accepts students without insurance and no student is turned away due to inability to pay for services.
To view in-network insurance plans, visit https://www.vnahealth.com/plans-insurance-accepted/
Please Note: If you have an HMO plan, you must see an in-network provider to avoid out-of-pocket costs.

Check the box next to the type of coverage that applies to you and fill out the required information.

☐ **Medicaid**
Plan Name: ____ Medicaid ID#: ________________________

☐ **Private/Commercial Insurance**
Plan Name: ____
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. ***Student Record Release:*** I authorize exchange of school and sports physicals and immunization information between VNA Health Care and West Aurora School District 129. I acknowledge that other information, as permitted by law, may be exchanged between VNA Health Care and West Aurora School District 129. ***Other Information Release:*** 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