CONSENT FOR HEALTHCARE SERVICES OF A MINOR

I, the parent/guardian/legal representative, agree to the following on behalf of myself and the patient:

1. **Scope of Available Services.** I have been informed of services by a Wellness Center healthcare provider and/or read the brochure or online information for the Loyola University Chicago Wellness Center (LUC WC) and have been informed of and understand the scope of the services offered to student by the LUC WC.

2. **Consent to treat.** I consent to medical and counseling treatment and services, diagnostic procedures and administration of medications deemed necessary and appropriate to treat the Patient’s condition or illness. I consent to the administration of vaccines mandated by Illinois state law or recommended by the Centers for Disease Control (CDC), including vaccinations for Tetanus, Diphtheria, Pertussis, Measles, Mumps, Rubella, and Influenza, unless medically contraindicated. I understand, consent, and agree that treatment may be provided by Physicians, Nurse Practitioners, Registered Nurses, Registered Dietitians, Psychiatrists, Psychologists, Licensed Clinical Social Workers and support staff who are employees of or provide services to Loyola University of Chicago. Students in training may, under the supervision of appropriate personnel, participate in the care and treatment of the Patient. Lab services may be provided at LUC WC. Electronic Health Record (EHR) will be used and the information in the EHR will be available to appropriate providers in the LUC WC. I understand that the treating providers will explain why treatment, counseling services, tests, or procedures are necessary and they will review common risks, benefits, and alternatives with the Patient. I also understand I have the right to refuse any treatment, procedure, or medications deemed medically necessary by my treating provider. I understand that I may revoke my consent at any time. This consent is voluntary and not mandatory.

3. **Conditions when Parental consent is not needed for the treatment of a minor include:**

   (410 ILCS 210/0.01) (from Ch. 111, par. 4500)
   Sec. 0.01. Short title. This Act may be cited as the Consent by Minors to Medical Procedures Act.
   (Source: P.A. 86-1324.)

   (410 ILCS 210/1) (from Ch. 111, par. 4501)
   Sec. 1. Consent by minor... is not voidable because of such minority, and, for such purpose, a married person who is a minor, a parent who is a minor, a pregnant woman who is a minor, or any person 18 years of age or older, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person of legal age.
   (Source: P.A. 93-962, eff. 8-20-04.)
Sec. 2. Any parent, including a parent who is a minor, may consent to the performance upon his or her child of a medical or surgical procedure. The consent of a parent who is a minor shall not be voidable because of such minority, but, for such purpose, a parent who is a minor shall be deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.
(Source: P.A. 93-962, eff. 8-20-04.)

Sec. 3. (a) ...emergency treatment or first aid or a licensed dentist renders emergency dental treatment to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, advanced practice nurse, physician assistant, dentist, or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.
(b) Where a minor is the victim of a predatory criminal sexual assault of a child, aggravated criminal sexual assault, criminal sexual assault, aggravated criminal sexual abuse or criminal sexual abuse, as provided in Sections 11-1.20 through 11-1.60 of the Criminal Code of 2012, the consent of the minor's parent or legal guardian need not be obtained to authorize a hospital, physician, advanced practice nurse, physician assistant, or other medical personnel to furnish medical care or counseling related to the diagnosis or treatment of any disease or injury arising from such offense. The minor may consent to such counseling, diagnosis or treatment as if the minor had reached his or her age of majority. Such consent shall not be voidable, nor subject to later disaffirmance, because of minority.
(Source: P.A. 96-1551, eff. 7-1-11; 97-1150, eff. 1-25-13.)

Sec. 4. Sexually transmitted disease; drug or alcohol abuse. Notwithstanding any other provision of law, a minor 12 years of age or older who may have come into contact with any sexually transmitted disease, or may be determined to be an addict, an alcoholic or an intoxicated person, as defined in the Alcoholism and Other Drug Abuse and Dependency Act, or who may have a family member who abuses drugs or alcohol, may give consent to the furnishing of medical care or counseling related to the diagnosis or treatment of the disease. Each incident of sexually transmitted disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations adopted under statute or ordinance. The consent of the parent, parents, or legal guardian of a minor shall not be necessary to authorize medical care or counseling related to the diagnosis or
treatment of sexually transmitted disease or drug use or alcohol consumption by the minor or the effects on the minor of drug or alcohol abuse by a member of the minor's family. The consent of the minor shall be valid and binding as if the minor had achieved his or her majority. The consent shall not be voidable nor subject to later disaffirmance because of minority.

Anyone involved in the furnishing of medical care to the minor or counseling related to the diagnosis or treatment of the minor's disease or drug or alcohol use by the minor or a member of the minor's family shall, upon the minor's consent, make reasonable efforts, to involve the family of the minor in his or her treatment, if the person furnishing treatment believes that the involvement of the family will not be detrimental to the progress and care of the minor. Reasonable effort shall be extended to assist the minor in accepting the involvement of his or her family in the care and treatment being given.

(Source: P.A. 88-670, eff. 12-2-94; 89-187, eff. 7-19-95.)

(410 ILCS 210/5) (from Ch. 111, par. 4505)

Sec. 5. Counseling; informing parent or guardian. Any physician, advanced practice nurse, or physician assistant, who provides diagnosis or treatment or any licensed clinical psychologist or professionally trained social worker with a master's degree or any qualified person employed (i) by an organization licensed or funded by the Department of Human Services, (ii) by units of local government, or (iii) by agencies or organizations operating drug abuse programs funded or licensed by the Federal Government or the State of Illinois or any qualified person employed by or associated with any public or private alcoholism or drug abuse program licensed by the State of Illinois who provides counseling to a minor patient who has come into contact with any sexually transmitted disease referred to in Section 4 of this Act may, but shall not be obligated to, inform the parent, parents, or guardian of the minor as to the treatment given or needed. Any person described in this Section who provides counseling to a minor who abuses drugs or alcohol or has a family member who abuses drugs or alcohol shall not inform the parent, parents, guardian, or other responsible adult of the minor's condition or treatment without the minor's consent unless that action is, in the person's judgment, necessary to protect the safety of the minor, a family member, or another individual.

Any such person shall, upon the minor's consent, make reasonable efforts to involve the family of the minor in his or her treatment, if the person furnishing the treatment believes that the involvement of the family will not be detrimental to the progress and care of the minor. Reasonable effort shall be extended to assist the minor in accepting the involvement of his or her family in the care and treatment being given.

(Source: P.A. 93-962, eff. 8-20-04.)
4. **Use and Disclosure of Patient Information.** I have read the LUC WC Confidentiality Agreement. I understand, consent, and agree that the LUC WC may receive, use and disclose information concerning the patient’s care, prescription medications, and health care, for evaluation, treatment, payment, and health care operations purposes including but not limited to the disclosures described in the Confidentiality Agreement and to medical, nursing, and mental health providers in order to facilitate the patient’s healthcare. I consent to the release of immunization records to LUC LOCUS account.

5. **Confidentiality Provision for the Patient.**
   
   (a) I understand that the confidentiality between the Patient and the LUC WC professionals described above will be maintained for specific health conditions and procedures when authorized by minors consent laws in the state of Illinois as listed above. In those situations, information about the Patient will not be given or discussed with me unless the Patient the Patient agrees. This means the Wellness Center will not talk about the Patient with me, the Parent/Guardian, unless the Wellness Center is given permission to do so by the Patient when the law gives the Patient the right to consent as a minor.

   (b) Except for Parent/Guardians, or as allowed in the “Use and Disclosure of Patient Information” section described above, or in the Confidentiality Agreement, or in the “Assignment of Benefits” section below; information about the Patient will not be given to anyone outside the LUC WC unless given explicit permission to do so or as required by law. This means the LUC WC will not talk about the student/patient to teachers, police, or anyone else unless I give permission to do so, or unless required by law.

   (c) The following are examples of additional exceptions in which LUC WC will have to talk to specific adults in order to protect the patient:

   1. An injury or accident happens on school property.
   2. The Patient tell us that they are being physically or sexually abused
   3. The Patient tell us that they plan to do harm to themselves or someone else
   4. The Patient has a life threatening condition

   For these exceptions the LUC WC will make every attempt to talk with the Patient first before we talk to anyone else.

   (d) Just as the staff at the LUC WC agrees to protect the Patient’s confidentiality, the Patient agrees to respect the confidentiality of all other students/patients that they may see in the LUC WC. This means that if your son/daughter sees another Patient in the WC and/or hears information about someone else that may be personal your son/daughter agrees to keep that information to themselves and not discuss it with anyone else.

6. I understand LUC WC will not have treating providers available at all times. When LUC WC is not available or in the event of a significant medical event or emergency the patient may have to proceed to the nearest Emergency Department or Urgent Care Facility.
7. **Charges.** I understand I am responsible for all charges associated with medicine received, procedures done, or tests done for the Patient at the Wellness Center. I understand the LUC WC does not submit bills to my insurance.

**Parent/Guardian:** I hereby voluntarily grant permission for Loyola University Chicago Wellness Center or authorized representatives to furnish such medical and counseling care as the Patient may require, including examinations, treatment, immunizations and so forth. This permission is conditioned upon the understanding that in the event of serious illness or the need for hospitalization and/or surgery, the Director/designee will use reasonable effort to contact me. Failure in such efforts, however, should not prevent the Director/designee from obtaining such emergency treatment as may be necessary under the circumstances.

Name of Patient____________________________

Relationship of Patient to Parent/Guardian____________________________

Name of Parent/Guardian____________________________ Date ________________

Signature of Parent/Guardian______________________________________________

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**Verbal consent:** Consent for treatment document reviewed verbally by phone with Parent/Guardian. Parent/Guardian gave verbal consent and verbalized understanding. Parent/Guardian was given the opportunity to ask and have questions answered.

Verbal consent for treatment obtained from____________________________ Date________

Relationship to patient _____________________________________________________

Consent obtained by________________________________________________________

Signature of person obtaining consent________________________________________ Date________

Third Party (non-Patient) witness to verbal consent___________________________

Signature of Third Party Witness____________________________________________ Date________