SIU SCHOOL of MEDICINE

Consent and Release for Screening

As parent or legal guardian of the child, _____ (Name), I give consent for SIU School of Medicine physicians, their associates, assistants, interns, residents, fellows, health care professionals, students and employees ("SIU Providers") participating in the _____ program as volunteers to perform a pre-enrollment physical examination screening for my child under this community based program. I also give SIU permission to release the results of the screening physical examination to _____.

It is my choice to allow my child to participate in this screening physical examination and I understand that it is without cost to me. I also understand that this is a screening exam and any health care provider who examines my child is not his/her personal provider. I understand that I am fully responsible for taking my child to his/her personal doctor for any health related problems or follow-up medical care and treatments that he/she may need. This screening examination does not replace the need in the future for me to take my child to his own doctor or a doctor that I choose for a medical examination, evaluation or follow-up care.

I along with my heirs, next of kin, legal and personal representatives agree to release and hold harmless, the Board of Trustees of Southern Illinois University and their employees, administrators and agents from any claims or legal causes of action as a result of any acts or failures to act by the SIU providers who volunteer to provide services in this physical examination screening.

I have read the above information and fully understand what I have read. I agree to the participation of my child in the physical examination screening.

_____ _____

Printed Name Parent/Legal Guardian Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Printed Name of Witness Date

_____ _____

Witness Signature and Title Date