**Demographics and Insurance Information**

I, (parent/guardian/student age 18 or older) , understand that the following information is needed to enter myself/my child into the computer system at the Kankakee County Health Department (KCHD) for purposes of keeping record of TB testing completed and billing my insurance/myself for services completed by KCHD. I understand that if the Kankakee County Health Department is unable to successfully bill my/my child’s insurance or I/my child does not have insurance coverage I will be sent a bill for $12.00 for a 1 step TB test and $24.00 for a 2 step TB test.

(Signature of parent/guardian/student age 18 or older) (date)

Please Print Clearly  
Demographics  
  
Student Name: DOB:   
Sex: Male/Female Race: Hispanic/Latino: Yes/No   
Address:   
City: State: Zip:   
Home Phone: Cell Phone:   
Emergency Contact Name: Relationship:   
Emergency Contact Phone Number:

Insurance Information

If no insurance coverage please indicate self-pay under insurance provider and fill out guarantor section to follow.

Insurance Provider/Company:   
Subscriber (who holds the policy): Subscriber DOB:   
Relationship to student: Policy ID number:   
Group Number:

Guarantor Information

Guarantor Name: Guarantor DOB:   
Relationship to student: Employer:   
Address if different than student:   
City: State: Zip: