HEALTH DEPARTMENT of Northwest Michigan

Parent/Guardian/Adult Consent for Services

STUDENT INFORMATION

Name: _____ Preferred Name: _____ Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female ☐ Other ☐ Decline Ethnicity: ☐ non/Hispanic ☐ Hispanic

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native American ☐ Asian ☐ Other ☐ Multiple

Street Address: _____ Mailing Address: _____

City: _____ Zip: _____

Student Phone Number: _____ Student Email: _____

Parent/Guardian Name: _____ Phone: _____ Legal Custody: ☐ Yes ☐ No

Relationship: _____ Email: _____

Parent/Guardian Name: _____ Phone: _____ Legal Custody: ☐ Yes ☐ No

Relationship: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SERVICES AVAILABLE

Our program is designed to provide connections to health care and community resources, assistance with Medicaid insurance enrollment, and coordination of care with school and parents/guardians and primary care provider, with proper release of information.

NURSING:

- Care for minor injury and illness
- Administration of some over-the-counter medications
- Coordination for chronic disease management
- Assessment of immunization record, we will not administer immunizations.
- Referral to primary care, oral healthcare, specialty service or mental health providers
- Health education or counseling
- Access to a nurse practitioner through telehealth services, including basic laboratory services

CONSENT FOR SERVICES POLICY

Parents/Guardians must provide consent for their minor children for services at the school wellness program. Minors without written consent will only be seen once with verbal parent/guardian permission. Exceptions to this policy, required by federal and Michigan laws*, include emergencies threatening life or limb, and substance use services. Minors 14 years and older can obtain limited mental health services not to exceed 12 sessions over 4 months, without parent/guardian consent. The school wellness program can offer referrals, if applicable, without parent consent for certain confidential services, allowed by federal and Michigan laws, not directly offered by the school wellness program. People who are 18 or older, legally emancipated, legally married, under court-order, in the presence of a law officer when the parent cannot be promptly located and/or members of the U.S. Armed Forces provide consent for themselves.

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By signing this consent form, I certify that I am the parent/legal guardian of the student named above and give consent for the following services:

I agree that I have reviewed and understand the Consent for Services Policy and the school wellness program services available. In addition, I acknowledge and consent that:

- This consent is valid while my child is enrolled at this current school building, and I can withdraw my consent, in writing, at any time.
- I understand that services can be refused or delayed at any time.
- All medical records are protected by the Health Insurance Portability and Accountability Act (HIPAA) and will only be released in accordance with the HDNW confidentiality and release of information policy, which is available for review.
- I authorize HDNW to release information regarding treatment and care to the following: health care providers, relevant school staff, and insurance companies. Information will only be shared as necessary for care or required through law.
- Services, including certain confidential services, that meet age criteria, operate in compliance with federal and Michigan laws.*
- I have been given or have had the opportunity to review the HDNW Notice of Privacy Practices.
- Testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate consent if a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- HDNW staff may access school records, such as PowerSchool, to coordinate appointments and services.

Signature of Parent/Guardian/Adult: _____ **Date:** _____

*Laws include Child Protection Law Act 238 of 1975, Civil Rights Act of 1991, Health Insurance Portability & Accessibility Act of 1996, Michigan's Mental Health Code which includes minor consent, Public Health Code, Communicable Disease Rules, and Medical Records Access Act.

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STUDENT INSURANCE INFORMATION		CONTACT ME FOR INFORMATION REGARDING
☐ No Insurance (Underinsured)	Policy Number:	☐ Health Insurance Options
☐ Medicaid/Medicaid HMO	Policy Holder Name:	☐ Finding a Healthcare Provider
☐ Blue Cross Blue Shield	Group Number:	☐ Finding a Dentist
☐ Blue Care Network	Policy Holder Birth Date:	☐ Paying for medical bills
☐ Priority Health	Relationship to Student:	☐ Emotional wellbeing of child or adult in my home
☐ Tricare		☐ Paying for transportation to Healthcare Provider
☐ Other:		☐ Help paying for heat/water/utility bills
		☐ Shelter ☐ Food ☐ Clothing

STUDENT HEALTH INFORMATION

Allergy (medicine, food, environment)	Reaction/severity

Medication (prescription, vitamins)	Dose	Frequency	Prescribed by	Reason for Medication

Check if your student has had any of the following:

☐ ADD/ADHD	☐ Anxiety	☐ Unexplained Tiredness	☐ Shortness of Breath/Asthma
☐ Autoimmune disorders	☐ Depression	☐ Blood disorder/cancer	☐ Head, Eyes, Ears, Throat Problems
☐ Anemia	☐ Sleep Problems	☐ Unexplained Weight Gain/Loss	☐ Blood Transfusions
☐ Birth Defects	☐ Abnormal Mood Swings	☐ Eating Concerns	☐ Anaphylactic Episodes
☐ Diabetes	☐ Seizures	☐ Stomach or Bowel Problems	☐ Joint or Muscle Pain or Stiffness
☐ Developmental Disorders	☐ Chest Pain	☐ Head Injury	☐ Physical/sexual/other trauma
☐ Developmental Disabilities	☐ Cognitive Impairment	☐ Headaches	☐ Other _____

Please describe anything checked above: _____

Serious injuries or illness (describe):_____

Surgeries (reason/date): _____

Hospitalizations (reason/date): _____

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Birth: ☐ C-section ☐ Vaginal ☐ Premature Birth: # weeks: ____Prenatal/Delivery Complications:

Any trouble meeting developmental milestones? (i.e. speech, gross/fine motor): ☐ No ☐ Yes; please explain below:

_____

_____

Student's Doctor: _____ Phone:_____

Student's Dentist: _____ Phone:_____

FAMILY MEDICAL HISTORY

Please indicate which of the student's blood relatives (mother, father, sibling, grandparent) have any of the following conditions:

☐ HIV/AIDS:_____
☐ Alzheimer's:_____
☐ Arthritis:_____
☐ Asthma:_____
☐ Blood Disorder:_____
☐ Bleeding Disorders:_____
☐ COPD/Emphysema/Bronchitis:_____
☐ Diabetes:_____
☐ Epilepsy/Seizures:_____
☐ Heart Attack/Stroke:_____
☐ High Cholesterol:_____
☐ Kidney Disease:_____
☐ Liver Disease/Hepatitis:_____
☐ Mental Illness:_____
☐ Osteoporosis:_____
☐ Thyroid Disorder:_____
☐ Tuberculosis/TB:_____
☐ Other:_____
☐ Other:_____
☐ Other:_____

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