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, a student health questionnaire (with consent), 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

MENTAL HEALTH:

- Individual, family and group counseling
- Crisis intervention
- Coordination of care with school, parents/guardians, nurse, healthcare providers
- Referral to nurse
- Referral to outside mental health provider
- Telehealth sessions

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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STUDENT HEALTH QUESTIONNAIRE POLICY

Health questionnaires give students and parents an opportunity to inform us about the students' physical and mental health. The Health Department of Northwest Michigan (HDNW) offers the School Health Questionnaire annually to all consented individuals.

CONSENT FOR STUDENT HEALTH QUESTIONNAIRE

I consent to the completion of the Student Health Questionnaire annually while my child is enrolled in the current school building.
My child may complete the child version: ☐ Yes ☐ No
Parent/Guardian may complete the parent version: ☐ Yes ☐ No

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: (check one)

☐ Mental health **AND** nursing services ☐ Mental health services **ONLY** ☐ Nursing services **ONLY**

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.
- I reviewed the Student Health Questionnaire and/or parent version, as applicable.
- 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:_______________________________________

*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, & Medical Records Access Act.