MidMichigan Community Health Services
2016-2017 School Based Health Center Consent Form
*****Must be Complete and signed to be Valid*****

Patient Information:				
Student Last Name:		**First:**		**Initial:**
Birth Date:	Age:	Male ☐ Female ☐ Transgender ☐	Grade:	School:

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Other_____

Ethnicity : ☐ Non-Hispanic ☐ Hispanic ☐ Arabic ☐ Other_____

Street/Mailing Address:	City/State	Zip Code

Parent/Guardian: Last Name	First Name	M.I.	Relationship to Student

Home phone # Cell #	Work phone #	Student cell #
Name of Emergency Contact:	Relationship to Student:	Telephone #
Pharmacy Preference:	Pharmacy Location:	Telephone #:

Preferred Method of Contact:
☐ Phone ( ) Home ( ) Cell ☐ Written Communication ☐ Other: _____

Name of Student's Primary Care Physician:	**Date of Student's Last Sports Physical:**	**Date of Student's Last Well Child Exam:**

INSURANCE INFORMATION: Please complete ALL relevant areas below.

Medicaid: (Circle One) Molina Meridian McLaren Other: _____		Medicaid ID#	
Primary Insurance and Address:	Subscriber Name: Subscriber Birth Date:	Subscriber/Policy Number:	Group #:
Secondary Insurance and Address:	Subscriber Name: Subscriber Birth Date:	Subscriber/Policy Number:	Group #:

DAILY MEDICATIONS: Please list any medications the student takes regularly.

	Name of Medicine:	***Dose: (mg)***	***Frequency***		***Name of Medicine:***	***Dose: (mg)***	***Frequency:***
1				***3***			
2				***4***			

Allergies to Medications:

STUDENT HEALTH HISTORY: Please X the YES column if any of these conditions apply to the student or mark here for ☐ NONE.

Condition:	***YES***	***Condition:***	***YES***	***Condition:***	***YES***	***Condition***	***YES***
Bee Sting allergies:		Seizure/Epilepsy:		ADD/ADHD:		Backaches:	
Food Allergies:		Anemia:		High Blood Pressure:		Sickle Cell Disease:	
Seasonal Allergies		Stomach Problems:		Fainting:		***Other Conditions:***	
Do you carry an Epi-Pen?		Heart Problems:		Pneumonia:			
Asthma:		Bladder Problems:		Shortness of Breath:			
Diabetes:		Surgeries:		Frequent Urination:			
Skin Disorders:		Hospitalizations:		Kidney Disease:			
Headaches/Migraines:		Pounding Heart:		Painful Joints:			

Please mark any boxes that an immediate family member (parents/siblings) has a significant medical history of:

Heart Problems		Cancer:		Seizures	
Asthma/Emphysema		Diabetes:		Kidney	
Death Under Age 50:		Stroke:		Other:	

OVER-SIGNATURE REQUIRED ON BACK!!!

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Please read the following statements and be sure that you understand each statement:

I give consent below for my child to receive services as indicated in this document. By signing this consent I certify that I am the legal guardian and legal custodian of the above listed student. I understand I may withdraw my consent at any time with written notice and I understand it is my responsibility to be sure the Health Center has received my withdrawal of consent.

I further authorize the Health Center to release information regarding treatment to other medical or mental health providers when needed for coordination of care, or to third party payers or others for purposes of receiving payment for services. I further authorize both the Health Center and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care. I give permission to the Health Center to obtain a copy of my child's immunization record from the MCIR, the school office or the local health department and make updates as needed. As recommended by the American Academy of Pediatrics, a routine risk behavior screening will be provided by the Health Center.

I understand that testing for blood borne diseases, including HIV/AIDS may be performed upon a patient without a separate written consent in the event that a healthcare professional from the Center sustains exposure to blood or body fluids from the patient's open wound, mucous membranes or occupational hazard.

I understand that as an entity of MidMichigan Community Health Services, the School Based Health Center participates in and recognizes the rules of the Health Insurance Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or communications by alternative means such as to a cell phone instead of the home phone.

The SBHC may confirm, for school attendance purposes only, the dates and times that a student was in the center. Protected Health Information is exempt from this communication.

The SBHC has a newly acquired Telemedicine System. By signing the consent form, you are giving the SBHC permission to communicate and consult with a MidMichigan Community Health Center doctor via Telehealth regarding your child's medical condition on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner.

Parental consent is required for the following services provided the student/patient is under the age of 18:	Current Michigan Law allows for confidential services to minors in these areas:
➢ Physical exams for school, sports and camps. ➢ Treatment for acute & chronic illness & injuries ➢ Vision/hearing screenings and follow-up ➢ Immunizations ➢ Basic laboratory services & tests ➢ Administration of medication ➢ Mental Health Services ➢ Referrals for specialty services	➢ Gynecological services ➢ Pregnancy testing and referrals ➢ Sexually transmitted disease screenings, treatment and counseling ➢ HIV screening and referrals ➢ Physical/sexual abuse counseling and referrals ➢ Crisis Intervention ➢ Substance abuse education, counseling and referrals ➢ Mental health assessment, counseling and referrals

Parental consent is not required for crisis intervention and emergency care.
Current Michigan Law prohibits School Based Health Centers from distributing or prescribing birth control pills or devices, or giving abortion counseling or referral information.

Sign Here

Student Name:	**Grade:**
Legal Parent/Guardian Signature:	**Date:**
Printed Name:	
***Parent E-Mail Address:** ***Optional: Will be used for Houghton Lake SBHC Listserv and Marketing Purposes ONLY**	

This School Based Health Center is sponsored by MidMichigan Community Health Services with funding from the Michigan Department of Health and Human Services and the Michigan Department of Education.