District Health Department #10
Healthy People, Healthy Communities

Shelby Adolescent Health Center 231-902-8550

PARENT/GUARDIAN/CLIENT CONSENT FORM

(Please read and complete front & back)

Student Name ______________________ **Date of Birth** __________ **Age** _____

Gender __________ **Grade** _____ **School** ___________ **Student Cell** __________ **Can we text you? Yes No**

SERVICES THAT MAY BE PROVIDED AT THE ADOLESCENT WELLNESS CENTER

- Physical exams for school, sports, and camp - may include vision & hearing tests, basic lab tests, etc.
- Primary health care services
- Sick care/minor illness
- Treatment for acute & chronic illness & injuries
- Over-the-counter medications
- Immunizations
- Educational/Support programs for smoking cessation, nutrition/fitness, parenting, etc.
- Referrals for specialty services
- *Physical/sexual abuse counseling and referrals
- *Substance abuse education, counseling and referrals
- *Mental health and psycho-social assessment, counseling, and referrals
- *Sexually transmitted infection & HIV testing treatment and counseling
- *Pregnancy prevention counseling, testing, and referrals

(*) Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent.

SERVICES NOT PROVIDED
NO distributing or prescribing birth control pills or devices
NO abortion counseling, referrals, or services

- I give my consent for the above named student to receive all services as indicated in this document.
  - ☐ If you do not want your child to be given any over the counter medications (i.e.Tylenol), check this box.
  - ☐ If you do not want your child to receive immunizations, check this box.
- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above.
- I understand that it is not necessary to renew my consent yearly, but it is necessary to have updated address, phone, insurance, and my child's current health information. I further authorize the Adolescent Wellness Center to release information regarding treatment to the following: Wellness Center staff and its' subcontractors, school staff when needed to coordinate services at school, and third-party payers when needed for payment of services. I understand I may withdraw my consent for services at any time upon written notice.
- I authorize both the Wellness Center and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care.
- I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics, and have the opportunity to give feed back on services and programs through surveys or focus groups.
- I understand my child may be administered a behavioral risk assessment during their appointment at our clinic.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I understand that I may be responsible for any insurance co-pays and immunization administration fees.
- I understand that services are provided with charges based on the client's income, and I understand no one will be denied services regardless of ability to pay.
- I understand that my privacy and health information will be handled in a confidential manner as required by the Health Information and Privacy Act as set forth by DHD#10 (see attached notice).

SIGNATURE OF PARENT/GUARDIAN/SELF: ______________________ **DATE:** __________

RETURN TO: Adolescent Health Center or school office

Shelby Adolescent Health Center

Registration/Billing Information

Student Name	**Birth Date**	**Race** ☐ **Am Indian/Alaskian** ☐ **Asian/Pacific Islander** ☐ **Black** ☐ **Multi-Racial** ☐ **White** ☐ **Unknown** **Ethnicity** ☐ **Arab** ☐ **Hispanic** ☐ **Non Arabic/Hispanic**

Address	**City**	**Zip Code**	**Home Telephone #**	**Parent Cell #**

Parent/Guardian	**Relationship to Student**	**Parent Work Phone #**
Name of Emergency Contact	**Relationship**	**Telephone #**

Does Student live with Parents? ☐ Yes ☐ No If no, where? ____________________

Insurance ** see below

☐ None (uninsured) Please contact me about helping attain MI Child/Healthy Kids health insurance for my child. ☐ Yes ☐ No

☐ Medicaid/MI Child ☐ Blue Cross/Blue Shield ☐ Priority ☐ Other: ____________________

☐ Mihealth Card Number (student's) ____________

I.D. #	Policy #	Group #	Coverage Code
Member Name	Birth Date	Social Security #	Relationship to Student

Member Employer	Employer's Address	Does your insurance pay For immunizations? ☐ Yes ☐ No

Registration/Billing Information Secondary Insurance (If Applicable)

☐ Medicaid/MI Child ☐ Blue Cross/Blue Shield ☐ Priority ☐ Other: ____________________

I.D. #	Policy #	Group #	Coverage Code
Member Name	Birth Date	Social Security #	Relationship to Student

Member Employer	Employer's Address	Does your insurance pay For immunizations? ☐ Yes ☐ No

*Please note: Services are not denied based on an inability to pay.

**** Please copy the front and back of your insurance card(s) and return it with this form. Thanks ☺**

Parent/Guardian/Self initials ______