VIKING WELLNESS CENTER

Located inside Grayling High School
1135 North Old 27, Room C309, Grayling, Michigan 49738
Phone: (989) 344-3540

PARENT/ GUARDIAN/ CLIENT CONSENT FORM

(Please read and complete front and back)

Student Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Grade:** _____ **School:** _____

Student Cell: _____ **Can we text you? (circle one)** **Yes** **No**

SERVICES THAT MAY BE PROVIDED AT THE VIKING WELLNESS CENTER

- Physical Exams for School, Sports, and Camps (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
- Education/ 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 Viking Wellness Center (VWC) to release information regarding treatment to the following: VWC 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 prior written notice.
- I authorize both the VWC 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 feedback on services and programs through surveys or focus groups.
- I understand that my child may be administered a behavioral risk assessment (RAAPS) 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 that 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 (HIPAA) as set forth by DHD #10 (see attached notice).

SIGNATURE OF PARENT/GUARDIAN/SELF: _____ **DATE**: _____

RETURN TO: *The Viking Wellness Center or the High School Office* **(Turn Over and Complete)**

ADOLESCENT HEALTH CENTER
Registration/ Billing Information

Demographic Information

Student Name	**Birthdate**	**Race** ☐ Am Indian/ Alaskan ☐ Asian/ Pacific Islander ☐ Black ☐ Multi-Racial ☐ White ☐ Unknown **Ethnicity** ☐ Arab ☐ Hispanic ☐ Non-Arabic/ Hispanic		
Address	**City**	**Zip Code**	**Home Phone #**	**Parent Cell #**
Parent/ Guardian	**Relationship to Student**	**Parent Work Phone #**		
Emergency Contact	**Relationship**	**Phone #**		

Does Student live with parents? _____ Yes _____ No If not, where? _____

***INSURANCE (**see below)**

_____ None/Uninsured (please contact me to help obtain MI Child/ Healthy Kids health insurance for my child) _____Yes _____ No

_____ Medicaid/ MI Child _____ Blue Cross/ Blue Shield _____ Priority _____ Other: _____

_____ MI Health (Student's Card Number:_____)

ID #	**Policy #**	**Group #**	**Coverage Code**
Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**
Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** _____ **Yes** _____ **No**	

SECONDARY INSURANCE (if applicable)

_____ Medicaid/ MI Child _____ Blue Cross/ Blue Shield _____ Priority _____ Other: _____

ID #	**Policy #**	**Group #**	**Coverage Code**
Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**
Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** _____ **Yes** _____ **No**	

*** Please Note: Services are not denied based on inability to pay.**
**** Please copy front and back of insurance card(s) and return it with this form.**

Parent/ Guardian/ Self Initials: _____