Chippewa Hills WELLNESS CENTER

Located inside Chippewa Hills High School
3226 Arthur Road, Remus, MI 49340
231-305-8674

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?** ☐ **YES** ☐ **NO**

SERVICES THAT MAY BE PROVIDED AT THE ADOLESCENT HEALTH CENTERS

- 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. Immunizations will not be given without specific written or verbal consent of the parent/guardian. Visit Michigan VIS for the most current Vaccine Information Statements (VIS).
- 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 Health Center (AHC) to release information regarding treatment to the following: Health 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 prior written notice.
- I 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 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 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).
- I understand that if face-to-face services are not available, telehealth may be an appropriate alternative. All existing laws that apply to face-to-face services also apply to telehealth.
- I understand reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth.
- I understand telehealth can include consultation, treatment, transfer of medical/mental health data, emails, telephone conversations and/or education using interactive audio, video, or data communications.

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

RETURN TO: *The Adolescent Health Center* **(Turn Over and Complete)**

ADOLESCENT WELLNESS 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 to Student**	**Phone #**

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

INSURANCE *Please, fill out completely. (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 _____

CLIENT MEDICAL HISTORY

NAME OF PRIMARY CARE PROVIDER:	DATE OF LAST PHYSICAL EXAM: MONTH: YEAR:	DATE OF LAST DENTAL EXAM: MONTH: YEAR:
MEDICATION ALLERGIES: ☐YES ☐NO TYPE:	OVERNIGHT HOSPITALIZATIONS: ☐YES ☐NO REASON:	MEDICATIONS (prescription, over-the-counter, and/or vitamins): ☐YES ☐NO ☐NOT APPLICABLE NAMES AND DOSAGES:
FOOD ALLERGIES: ☐YES ☐NO TYPE:	SURGERIES: ☐YES ☐NO TYPE:	
ALLERGIES (i.e. dust, pollen, etc.): ☐YES ☐NO TYPE:	BROKEN BONES: ☐YES ☐NO DESCRIBE:	
BEE STING ALLERGY? ☐YES ☐NO		

ADD/ADHD	☐YES ☐NO	ASTHMA	☐YES ☐NO	DIABETES (high blood sugar)	☐YES ☐NO
LD/ SPECIAL NEEDS	☐YES ☐NO	SHORTNESS OF BREATH	☐YES ☐NO	CANCER	☐YES ☐NO
HEADACHES/ MIGRAINES	☐YES ☐NO	HEART PROBLEM	☐YES ☐NO	STOMACH PROBLEMS	☐YES ☐NO
SEIZURE	☐YES ☐NO	MURMUR	☐YES ☐NO	KIDNEY/ URINARY PROBLEMS	☐YES ☐NO
ECZEMA/ RASHES	☐YES ☐NO	HYPERTENSION (high blood pressure)	☐YES ☐NO	DEPRESSION	☐YES ☐NO
ANEMIA (low iron/ blood count)	☐YES ☐NO	FAINTING	☐YES ☐NO	ANXIETY	☐YES ☐NO
OTHER (please specify):					

Additional Information:

_____

_____

FAMILY MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY	PLEASE NOTE WHICH RELATIVE THAT HAS/HAD THIS CONDITION
☐ ASTHMA/ EMPHYSEMA/ COPD	
☐ HYPERTENSION (high blood pressure)	
☐ HIGH CHOLESTEROL	
☐ CANCER (please specify type)	
☐ DIABETES (high blood sugar)	
☐ STROKE	
☐ SEIZURES	
☐ KIDNEY PROBLEMS	
☐ HEART PROBLEMS	
☐ MENTAL HEALTH CONCERNS (please specify)	
☐ DEATH UNDER AGE 50 CAUSE:	
☐ OTHER	

Additional Information:

_____

_____

RESOURCE ASSISTANCE

WOULD YOU LIKE INFORMATION FROM OUR STAFF REGARDING THE FOLLOWING? ☐YES ☐NO	DO YOU HAVE CONCERNS ABOUT THE EMOTIONAL WELL-BEING OF YOUR CHILD? ☐YES ☐NO
-OPTIONS FOR HEALTH INSURANCE? ☐YES ☐NO	ARE YOU CONCERNED ABOUT YOUR INCOME MEETING THE BASIC NEEDS OF YOUR FAMILY? ☐YES ☐NO
-FINDING A HEALTH CARE PROVIDER? (doctor or nurse practitioner) ☐YES ☐NO	Please circle concerns: ☐FOOD ☐CLOTHING ☐HOUSING ☐HEAT/WATER BILLS ☐TRANSPORTATION TO MEDICAL OR SCHOOL APPTS
-FINDING A DENTIST? ☐YES ☐NO	
DO YOU OR ANY OF YOUR FAMILY HAVE ANYTHING YOU WOULD LIKE TO DISCUSS WITH THE COUNSELOR? ☐YES ☐NO	**IF YOU ANSWERED YES TO ANY OF THE ABOVE, A MEMBER OF OUR STAFF MAY CONTACT YOU.**

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

For office use:

Reviewed with client: _____ DATE: _____

The Adolescent Wellness Center is operated by District Health Department #10 with major funding from the Michigan Departments of Health and Education.

DISTRICT HEALTH DEPARTMENT #10 CLINIC SIGNATURE FORM

Patient Name: _____ **Birthdate:** _____

I give my permission to District Health Department #10 to release my medical information to my medical insurance provider as required for billing purposes.
If your service(s) are not a covered benefit under your insurance plan, and you have not met your deductible and/or co-pays or are out of network, you will be billed for the cost of service(s) and/ or administration fees as directed by the state of Michigan.
I acknowledge receiving a current Notice of Privacy Practices on _____ from District Health Department #10.
(date)

IMMUNIZATION CLIENTS:

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. If your service(s) are not a covered benefit and you are eligible for the VFC program (Vaccines for Children), you will be billed the administrative fee only.

I understand that the notice contains my rights and the Health Department's responsibilities with regard to my protected health information. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific service(s) and I ask that the service(s) I have requested be given to me, or the person named above for whom I am authorizing to make this request and I ask that the administration of the service(s) be recorded.

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

*For more information about the Adolescent Health Center, and your rights associated with the transmission of your information through this and other health information exchanges, please contact Christine Lopez via email: clopez@dhd10.org