Health Services Consent Form

Child & Adolescent Health Centers
School Wellness Programs

Student Name:_____ **Birthdate:**_____/_____/_____

Consent for Services

Services may include: mental health services (individual, family and group counseling); and medical services, including: treatment for acute illness and injuries; physical exams for school, sports, and camp; basic laboratory services and tests; referral for specialty health services; student health assessment, education, and risk counseling and testing; Medicaid outreach and enrollment; administration of over the counter medications , i.e., ibuprofen, acetaminophen, loratadine in accordance with established protocols developed by Grace Health and allow consultation with a Grace Health Nurse Practitioner via Telehealth regarding the patient's medical condition on an as-needed basis. Not all services are available with all programs.

- For Parents/Guardians – I give consent for my student to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I authorize Grace Health to bill my insurance company and release related information necessary to complete the billing process for services provided. I further authorize the exchange of health care information regarding treatment to other medical or mental health providers for the purpose of continuity and coordination of care. I agree to allow conversation with school staff when academic success is related to a health issue. I understand I may withdraw my consent for services at any time upon written notice. I understand that I may be billed for services not covered by insurance due to failure to comply with insurance requirements, i.e., Coordination of Benefits.
- I understand that testing for blood borne 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 blood or body fluids.
- I understand that as an entity of Grace Health, these programs participate in and recognize the rules of the Health Information 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/records. Access to these records is not permitted without consent of the student. In a medically-appropriate situation, pertinent information will be given to the parent/guardian and/or others as permitted or required by law. 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.
- I have been given or have had the opportunity to review the Grace Health Notice of Privacy Practices (located at https://www.gracehealthmi.org/privacy-practices/) and may also be provided a copy upon request.
- I have reviewed, understand and consent to the services offered.
- By signing this form I certify that I am the legal guardian and/or legal custodian of the student listed above.

_____ _____
Signature of Parent/Guardian/Client 18 years and older **Date**

Consent for Immunizations

I understand immunization (shot) records from the Michigan Care Improvement Registry (MCIR) will be reviewed. I give my permission for any required or recommended shots(s) to be given if needed and that the administration be recorded in MCIR.
View vaccine information sheets at: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4914-138197--,00.html#Vaccine_Information_Statements_(VIS)

_____ _____
Signature of Parent/Guardian/Client 18 years and older **Date**

Consent to Photograph

I hereby grant permission to Grace Health for photographs/video to be taken for the purpose of marketing and media coverage. It is understood that Grace Health is not responsible for any event, action, or judgment that may result from the photographs/video.

_____ _____
Signature of Parent/Guardian/Client 18 years and older **Date**

Michigan law mandates (requires) confidential services to minors without the consent or knowledge of a parent/guardian. Confidential services include advice, testing and/or treatment for drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services. There is no specific age set forth in the law. This applies to any minors who understand the nature and consequences of their actions. Additionally, a minor 14 years of age or older can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. People who are age 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 US Armed Forces provide consent for services themselves. Services are rendered without regard to sex, race, religion or sexual orientation.

No birth control pills or devices are dispensed or prescribed by these programs. The student will be given a referral list of community agencies that provide these services. No abortion counseling, referrals, or services are provided.

All medications to be administered by school/Grace Health staff, or self-carried by the student, require the Medication Administration Authorization Form to be completed by the parent and medical provider/prescriber prior to administration. ALL medications must be in original, properly labeled containers and dispensed by a medical provider/prescriber/pharmacist or be in original over the counter packaging.

CRISIS INTERVENTION AND EMERGENCY CARE DO NOT REQUIRE PARENTAL CONSENT

Registration & Health History Form

Student Last Name:	**First:**	**Middle Initial:**	**Preferred Name:**

Birth Date:	Sex: ❒ Male ❒ Female	School:	Grade:

Race: ❒ White ❒ Black/African American ❒ Native Hawaiian ❒ Other _____
❒ American Indian or Alaskan ❒ Other Pacific Islander ❒ Asian ❒ Choose not to disclose

Ethnicity: ❒ Non-Hispanic or Latino ❒ Hispanic or Latino ❒ Unreported/Choose not to disclose

Street/Mailing Address:	City/State:		Zip Code:
Parent/Guardian: Last Name:	First Name:	Initial:	Relationship to Student:
Phone Contact Number:			
Name of Emergency Contact:	Relationship to Student:		Telephone Number:
Pharmacy Preference:			

INSURANCE INFORMATION: Please complete ALL relevant areas below.

Insurance: ❒ Yes ❒ No Please contact me about MI Child/Healthy Kids Health Insurance for my child: ❒ Yes ❒ No

Primary Insurance:	Subscriber Name: Subscriber Birth Date:	Subscriber/Policy Number:
Secondary Insurance:	Subscriber Name: Subscriber Birth Date:	Subscriber/Policy Number:

Name of Primary Care Physician:	Date of Last Physical:

Allergies to Medications:

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

	Name of Medicine		***Name of Medicine***
1		**3**	
2		**4**	

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***	***Other Conditions:***
ADHD/ADD		Diabetes		
Allergies:		Emotional Behavior		
• Bee Sting		Experienced Trauma Event		**Surgeries/Hospitalizations:**
• Food		Headaches/Migraines		
• Seasonal		Seizures		
Emergency treatment needed? Y / N		Emergency treatment needed? Y / N		
Asthma		Second Hand Smoke		
Emergency treatment needed? Y / N		Other:		
Cancer				

FAMILY HEALTH HISTORY (parents/siblings): Please X the YES column if any of these conditions apply to the family or mark here for ❒ NONE.

Condition	***YES***	***Condition***	***YES***	***Other Conditions:***
Allergies:		Emotional Behavior		
		Heart attack or death before age 50		
Asthma		Hypertension/High Blood Pressure		
Cancer		Overweight/Obesity		
Cholesterol Elevated		Seizure		
Diabetes: Type I or II (please circle)		Smoking		