



# CHILD AND ADOLESCENT HEALTH PROGRAM

## Parent/Guardian - Consent for Services Form

<b>Child/Adolescent Name</b>		<b>Birth Date</b>	<b>Age</b>	<b>Gender</b>	<b>Grade</b>	<b>School</b>
<b>Street Address</b>			<b>City</b>	<b>Zip Code</b>	<b>Phone Number</b>	
<b>Race (Optional)</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> More Than One <input type="checkbox"/> Other						
<b>Ethnicity (Optional)</b> <input type="checkbox"/> Non-Arabic/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Arabic						
<b>Parent/Guardian Last Name</b>	<b>Parent/Guardian First Name</b>	<b>Parent/Guardian Last Name</b>	<b>Parent/Guardian First Name</b>			
<b>Daytime Telephone Number</b>		<b>Cell Phone</b>		<b>E-Mail Address</b>		
<b>Name of Emergency Contact (other than parent/guardian)</b>			<b>Relationship</b>	<b>Telephone Number</b>		

### Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor children for services at the health center. Students without a consent form signed by a parent/guardian on file will not be seen, except for a student's first visit to the health center, when staff will telephone parent/guardian for verbal consent on a one-time-only basis. The only other exceptions, according to Michigan law are: emergencies threatening life or limb; and specific services related to substance use treatment; sexual health and reproductive health (such as pregnancy testing, prenatal care, birth control information, contraceptives, testing and treatment for sexually transmitted infections (STIs), including HIV); and-- for minors 14 and older—mental health services. 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.

*The health center does not provide abortion counseling, services, or referrals.*

By signing this form, I certify that I am the legal guardian and legal custodian of \_\_\_\_\_  
Student's name

### Consent for Services

Health center services include: mental health services (individual, family and group counseling); medical services, such as primary care; well child checks/comprehensive physical exams; treatment for illness and injuries; physical exams for school, sports, and camp; basic laboratory services and tests; referral for specialty health services (including dental care); student health assessment, education, and risk reduction programs (including reproductive health education); chronic disease management; sexually transmitted disease testing, prevention, and treatment; pregnancy testing; HIV counseling and testing; immunizations; medication administration; vision/hearing screenings; and Medicaid Outreach and enrollment.

- I have reviewed and understand the services offered by the health center.
- For Parents/Guardians: I give consent for my child to receive the services described above until age 18.
- I understand it is not necessary to renew my consent yearly. I further authorize the Child and Adolescent Health Center to release information regarding treatment to the following: Health Center staff and its subcontractors, and other health care providers when needed to coordinate care; 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 give consent for my child to be transported by MTA Rides to/Wellness to/from their school to the Hamilton School-Linked Health Clinic at G-3373 S. Saginaw Street, Burton, MI 48529.
- I received a copy of Hamilton Community Health Network's Notice of Privacy Practices.
- I understand that Hamilton Community Health Network is a HIPAA-covered healthcare provider, and an independent partner to Flint Community Schools. My child's health information from the School-Linked Health Center is protected by HIPAA and will only be shared with school personnel when needed to coordinate services at school, and only as authorized by me. The school does not have access to my child's medical information unless I authorize it.
- 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 give consent for my/my child's height and weight to be entered into the Michigan Childhood Immunization Registry (MCIR).
- I understand that if needed, telehealth technology will be used to connect with an advanced practice provider to work together for a diagnosis and treatment plan for medical services provided, or a mental health professional to allow for the provision of counseling services.

\_\_\_\_\_  
 Signature of Parent/Guardian/Client 18 years and older

\_\_\_\_\_  
 Date

**Please see back for additional information**

Child/Adolescent Name

### Immunization Consent

#### Consent for Immunizations

I understand my/my child's immunization (shot) records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that I/my child needs a shot, I give my permission for it to be given at the Child and Adolescent Health Center, and I give permission that the administration of the vaccine be recorded in the Michigan Childhood Immunization Registry. I understand a letter with the needed shot and Vaccine Information Sheet(s) will be sent home for my review. My child may come to the appointment without me for vaccine administration. If I do not want the shot given to me/my child, I need to call or write to the Child and Adolescent Health Center before the planned shot day.

Signature of Parent/Guardian/Client 18 years and older

Date

### Insurance Information

#### HEALTH INSURANCE (Please complete all information)

None (uninsured) Please contact me about MICHild/Healthy Kids health insurance for my child.  Yes  No

Medicaid/Medicaid HMO \_\_\_\_\_ Child's Card Number \_\_\_\_\_

Blue Cross/Blue Shield of Michigan

Blue Care Network

Genesee Health Plan

TriCare

Other: \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_

Insurance Policy Number \_\_\_\_\_

Insurance Group Number \_\_\_\_\_

Birth Date of Policy Holder \_\_\_\_\_

Relationship of Policy Holder to child?  
\_\_\_\_\_

Does your insurance pay for immunizations?  Yes  No

### Additional Information

1. Would you like information from our staff regarding:

Options for health insurance?

Yes  No

Finding a health care provider (doctor or nurse practitioner)?

Yes  No

Finding a dentist?

Yes  No

2. Do you or any of your family members have anything you would like to discuss with the Social Worker?

Yes  No

Do you have concerns about the emotional well being of yourself/your child?

Yes  No

3. Are you concerned about your income meeting the basic needs of your family?

Yes  No

Please mark your concerns:

Food  Clothing  Housing  Paying for bills for heat and water

Dentist  Doctor  Mental Health Needs  Transportation to medical appointments or school

*If you answered YES to any of the above, a member of our staff will contact you*

Please see back for additional information

Child/Adolescent Name

**CLIENT AND FAMILY HISTORY FORM (Please write "NA" if nothing to report)**

Name of Student's Physician or Clinic		Physician or Clinic Telephone Number		Name of Student's Dentist	
Name of Pharmacy				Pharmacy Telephone Number	
Allergy (Medicine, food, environment, seasonal)				Reaction/Severity	
Medication/Prescription/Vitamins	Dose	Frequency	Route	Who prescribed this medication?	Reason

Last Complete Physical Exam \_\_\_\_\_ Last Dental Exam \_\_\_\_\_ Last Eye Exam \_\_\_\_\_

Disease/Condition	Client	Mother	Father	Sibling	Grand-parent	Other	Comment
Addiction – Type:							
Anemia							
Asthma - Specify							
Autoimmune disorder							
Birth defects							
Blood/Bleeding disorders							
Cancer							
Death Under Age 50 - Cause:							
Developmental Disability							
Diabetes							
Eating disorders/Special diet/Pica							
Endocrine/Thyroid							
Gastrointestinal disorders							
Genetic abnormalities							
Heart disease							
Heart abnormalities/Murmurs							
Hepatitis/Liver disease							
High Cholesterol							
Hypertension							
Kidney/Urinary disease							
Learning Disorder							
Musculoskeletal disorders							
Neurologic disorder/Seizures							
Obesity/Overweight							
Physical/Sexual/Verbal/Domestic Abuse							
Psychiatric disorders/ Depression/Suicide - Specify							
Skin disorder - Specify							
Stroke							
Other							

Please see back for additional information

Child/Adolescent Name

**CLIENT HISTORY** – Please check if your child has had or does have any of these conditions.

Condition	Date of Onset	Comment
ADD/ADHD		
Anaphylaxis		
Autism		
Backaches/Back injury		
Fainting		
Frequent sore throat		
Frequent urination/Bladder conditions		
Problems with head, eyes, ears, nose, or throat		
Headaches		
Hearing problems		
Hernias		
Nosebleeds		
Pneumonia		
Problems with childhood vaccines		
Rheumatic Fever		
Shortness of breath		
Other:		
<b><i>Substance Use/Exposure</i></b>		
Alcohol		
Chew/Tobacco/Cigarettes/Vaping		
Cocaine		
Marijuana		
Secondhand smoke		
Other:		
<b><i>Surgery/Hospitalizations</i></b>		
Adenoids removed		
Appendectomy		
Asthma Exacerbation		
Ear tubes		
Fracture		
Head injury/Concussion		
Heart Surgery		
Premature birth		
Tonsillectomy		
Trauma		
Other:		

Reviewed with client \_\_\_\_\_  
 \_\_\_\_\_  
 Initials Date

*Please return completed consent form to:*

**School Office or School Nurse at  
 Flint Southwestern Classical Academy / ALA or  
 Holmes STEM Middle School Academy**

**For questions on completing or returning this consent form please call:  
 Jennifer Holland, BSN, RN  
 Supervisor of Health Services, Flint Community Schools  
 (810) 424-4087**