Cherry Health

School Based Health Center Consent Form

Student's name: _____ Date of birth: _____

School: _____ Grade: _____

Services provided:

- Physical exams for school, sports & camp
- Treatment for acute & chronic illness & injuries
- Vision/hearing screenings and follow-up
- Dental exams, cleanings & X-rays
- Immunizations
- Basic laboratory services & tests
- Crisis intervention*
- Administration of medication
- Referrals for specialty services
- Substance use education, counseling & referrals*
- Individual, group, family & community education
- Mental health and psychosocial assessment, counseling & referrals*
- STD and screening checks*

(*)Current Michigan Law states that these services do not require parental consent.

Services Not Provided:
No birth control pills or devices are dispensed or prescribed.
No abortion counseling, referrals or services provided.

If you want your child to receive any of the following services, please check the "consent box" next to each service, sign and date the bottom of the second page and return this form to your child's school.

Medical Care

☐ **I consent for my child to receive medical care** through the School Based Health Center.

Please note: all required and recommended vaccinations will be given unless otherwise specified by the parent or guardian.

Does your child have health insurance? Y / N

Medical insurance (choose one):

Medicaid #: _____

Insured: _____

Name of insured parent, insurance name and policy #

Other: _____

Where do you take your child to see the doctor? _____

Phone #: _____ Date of last physical exam: _____

List of allergies to medicines, foods, bee stings, etc.: _____

List of current medications your child is taking: _____

_____ Pharmacy: _____

Does the child have any medical problems including learning/physical disabilities? Y / N If yes, please list.

_____ _____

Does the child's siblings or parents have any medical problems or history of cancer? Y / N If yes, please list.

_____

Has your child ever been a patient in the hospital overnight? Y / N

If yes, why? _____

Has your child ever had any surgeries? Y / N If yes, describe: _____

Dental Care

☐ **I consent for my child to receive dental care** through the School Based Health Center. Some treatments may be delivered by a hygienist or assistant.

Does your child have dental insurance? Y / N

Dental insurance (choose one):

Medicaid #: _____

Insured: _____

Name of insured parent, insurance name and policy #

Other: _____

Where do you take your child to see the dentist? _____

Phone #: _____ Date of last dental exam: _____

Counseling Services

☐ **I consent for my child to receive counseling services** (Examples: one-on-one counseling, community resource referrals and outreach and coordination of outside resources and/or services).

If the patient is 14 years or older, parental consent is not required.*

Patient name: _____ DOB: _____ Grade: _____

Parent/Guardian Information

Mother/Guardian: _____DOB: _____ Home/work phone: _____
Father/Guardian: _____ DOB: _____ Home/work phone: _____
Parent/Guardian address: _____
Email address: _____
Emergency contact: _____ Relationship: _____ Phone #: _____
Household annual income $: _____ # of people in household: _____
What language is most often spoken at your home? _____
Is there any other important health information we should know? _____
_____
Would you like to request any other assistance, or have any comments to help the health center serve you better?
_____

Additional Information

Please check the box that best describes your child's race:

□ American Indian/Alaskan Native □ Asian □ Black/African American
□ More Than One Group □ Native Hawaiian □ Other Pacific Islander
□ White □ Decline to specify □ Unknown

Please check the box that best describes your ethnicity:

□ Latino or Hispanic □ Not Latino or Hispanic □ Decline to specify

Please check any box that describes your child's current housing situation:

□ Doubling Up (living with extended family, friends, or acquaintances) □ Shelter
□ Not Homeless (legally occupied, single family, owned or rented) □ Other
□ Street (on the street, in cars, abandoned buildings, under bridge) □ Unknown/Unreported
□ Transitional (treatment program, hospital, jail, motel)

Please circle Y or N based on you or your family's primary source of income:

1. In the last 24 months have you worked on a farm/orchard planting or harvesting crops? Y N

If you answered no, you may skip the next 3 questions.

1. In order to work in agriculture, have you moved during the past 2 years? Y N
2. Due to the seasonal nature of your work in agriculture, have you had to change jobs, reduce the number of hours you work, or been temporarily laid off during the past 2 years? Y N
3. Have you or family you live with stopped working in agriculture due to disability or old age? Y N

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

_____

Parent/Guardian Signature **Date**

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into MCIR (Michigan Care Improvement Registry), dental and mental health records. I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives his/her health care services and on the Cherry Health website.