Honor Community Health School Based Health Center
Consent Form for Medical and Dental Services

Student Information							
Last Name		First Name				Middle Initial	
Date of Birth		Social Security Number					
Age		Student Cell Phone #:					
Grade		School					
Address		City		State:		Zip Code	
Parent/Legal Guardian Information							
Last Name		First Name					
Date of Birth		Social Security Number					
Phone #		Preferred Language					
Emergency Contact Information (Complete only if contact is <u>not</u> the same as the parent/guardian)							
Last Name		First Name					
Phone #		Relationship to Student					

Services Provided at the School-Based Health Center

<u>Parental Consent is required</u> for the following services provided to patients under the age of 18:

- Health maintenance Exams
- Treatment for acute and chronic illnesses and injuries
- Oral/dental screenings and follow up
- Basic laboratory services and tests
- Individual, group, family and community education
- Physical exams for school, sports, camp and work
- Vision/hearing screenings and follow up
- Immunizations
- Medication administration
- Referrals for specialty services

Current Michigan law allows for confidential services to minors aged 12 and up. <u>Parental consent is not required for:</u>

- Pregnancy testing
- HIV counseling, testing, and referrals
- Substance abuse education, counseling, and referrals
- Mental Health and psycho-social assessment, counseling, and referral (must be 14+ to consent)
- Sexually Transmitted Infection screenings, treatment/counseling
- Physical/sexual abuse counseling and referrals
- Crisis intervention and emergency care

Services Not Provided at the School-Based Health Center

Per Michigan Law:

- Birth control pills and contraceptive devices are not dispensed or prescribed on school premises
- Abortion counseling, referrals, or services are not provided

Parent/Guardian Consent

I consent to the following:

- The above-named student may receive all services listed above at the School-Based Health Center
- Exchange of healthcare information between the School-Based Health Center and the student's primary care physician and other established healthcare providers for continuity and coordination of care according to state & federal laws
- Release of information regarding treatment to third party payers or others for the purpose of receiving payment for services
- In certain situations, the delivery of care may include telemedicine:
    - My health care provider has explained how the video conferencing technology will be used to affect a consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider
    - I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
    - I understand others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time

By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the above-named student and the insurance information is current and correct. I understand that I may withdraw my consent or refuse services upon written notice to the health center at any time.

Parent/Guardian Signature		Date:	

Additionally, by checking each box below, I consent to the following:

☐ The above-named student may receive COVID-19 evaluation, testing and treatment by the School-Based Health Center. All students who have received COVID-19 testing through the School-Based Health Center will have results communicated to the parent/guardian as well as school administration prior to returning to school. I understand that positive test results require reporting to the Oakland County Health Department.

☐ Immunizations – I understand my child's immunization records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that my child needs a shot, I give my permission for it to be given at the School-Based Health Center, and I give permission that the administration of the vaccine be recorded in the MCIR. I understand that I will be able to review a written description of the vaccine and/or talk with a vaccine administrator prior to the vaccine being given.

Primary Insurance Information

Insurance Company		Policy ID		Group/Plan #	
Name of Policy Holder		Relationship to Student			

Secondary Insurance Information

Insurance Company		Policy ID		Group/Plan #	
Name of Policy Holder		Relationship to Student			

Patient Health History

Gender at Birth	☐ Female ☐ Male	Current Gender	☐ Female ☐ Male	☐ Transgender Male (Female to male) ☐ Transgender Female (Male to female)	☐ Choose not to disclose ☐ Other: _____
Sexual Orientation	☐ Straight/Heterosexual	☐ Lesbian or Gay	☐ Bisexual	☐ Something else	☐ Don't Know ☐ Choose not to disclose
Race	☐ American Indian or Alaska Native ☐ White or Caucasian	☐ Asian or Pacific Islander ☐ More than one race		☐ Black or African American ☐ Other: _____	
Ethnicity	☐ Hispanic/Latino ☐ Not Hispanic/Latino	☐ Arab ☐ More than one ethnicity	Preferred Language	☐ English ☐ Spanish	☐ Arabic ☐ Other: _____
Living Situation	☐ Not Homeless (Family owns or rents a home/apartment)	☐ Homeless	Are you worried about losing your housing?	☐ Yes	☐ No
Student's Primary Care Doctor			Phone #:		
Student's Dentist			Phone #		
Date of Last Physical	____/____/_____		☐ Don't remember		

Current Medications: (please include dosage and reason for taking)

Medication Name: _____ Dose: _____ Reason:_____

Medication Name: _____ Dose: _____ Reason:_____

Allergies	☐ Medication (please list): _____	☐ Food (please list): _____
	☐ Seasonal (hay fever, dust, pollen) ☐ Bee Stings	☐ Other: _____

Please check if your child has any of the following:

☐ Anemia	☐ Asthma	☐ Attention Deficit Disorder (ADD)	☐ Blood disease
☐ Cancer	☐ Dental Problems: _____	☐ Diabetes	☐ Emotional Impairment or Mental Illness
☐ Fainting	☐ Headaches/Migraines	☐ Head Injury	☐ Heard Murmur
☐ Heart Problems:_____	☐ HIV/AIDS	☐ Hypertension (High blood pressure)	☐ Jaundice
☐ Kidney or Bladder/Urine problem	☐ Liver Disease	☐ Menstrual Problems:	☐ Pregnancy: Due Date:
☐ Rheumatic Fever	☐ Seizures (with or without epilepsy)	☐ Sickle Cell Trait	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Skin Problems	☐ Stomach Problems	☐ Venereal Disease

☐ Other Health Problems: _____

Family Medical History: Please check if any of your child's relatives have had any of the following illnesses and note which relative had them

☐ Asthma	Who: _____	☐ Hypertension	Who: _____
☐ Anxiety, depression, or other mental illness	Who: _____	☐ High Cholesterol	Who: _____
☐ Cancer	Who: _____	☐ Kidney Problems	Who: _____
☐ Death under age 50	Who: _____	☐ Seizures	Who: _____
☐ Diabetes	Who: _____	☐ Sickle Cell Anemia	Who: _____
☐ Heart Problems	Who: _____	☐ Stroke	Who: _____