



Located inside Brethren High School
4400 N High Bridge Rd, Brethren, MI 49619
Phone: (231) 309-8955

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

- Educational/Support programs for smoking cessation, nutrition/fitness, parenting, etc.
- Referrals for specialty services
- Referrals to services for other clinic and/or primary care providers
- *Physical/sexual abuse counseling and referrals
- *Substance abuse education, counseling and referrals
- *Mental health and psycho-social assessment, counseling, 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**

- 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 Wellness Center to release information regarding treatment to the following: Wellness 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 written notice.
- I authorize both the Wellness 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 my child may be administered a behavioral risk assessment (RAAPS) during their appointment at our clinic.
- I understand that I may be responsible for any insurance co-pays and immunization administration fees.
- I understand that services are provided with charges based on the client's income, and I understand 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 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 <input type="checkbox"/> Am Indian/ Alaskan <input type="checkbox"/> Asian/ Pacific Islander <input type="checkbox"/> Black <input type="checkbox"/> Multi-Racial <input type="checkbox"/> White <input type="checkbox"/> Unknown Ethnicity <input type="checkbox"/> Arab <input type="checkbox"/> Hispanic <input type="checkbox"/> 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:			DATE OF LAST DENTAL EXAM:		
			MONTH: YEAR:			MONTH: YEAR:		
MEDICATION ALLERGIES: YES NO			OVERNIGHT HOSPITALIZATIONS: YES NO			MEDICATIONS (prescription, over-the-counter, and/or vitamins): YES NO NOT APPLICABLE NAMES AND DOSAGES: _____ _____ _____		
TYPE:			REASON:					
FOOD ALLERGIES: YES NO			SURGERIES: YES NO					
TYPE:			TYPE:					
ALLERGIES (i.e. dust, pollen, etc.): YES NO			BROKEN BONES: YES NO					
TYPE:			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: _____

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:** _____