

Student/Patient Name		Birth Date	Age	Male <input type="checkbox"/>	Grade	Homeroom	School
				Female <input type="checkbox"/>			
Race (Optional): <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Arab American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Choose not to Report							
Ethnicity (Optional): <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Arabic							
Address		City		Zip Code		Home Telephone Number	
Parent/Guardian: Last Name		First Name			M.I.	Relationship to Student/Patient	
Daytime Telephone Number		Work Telephone Number		Cellular / Pager Number			
Name of Emergency Contact		Relationship to Student/Patient			Telephone Number		
Name of Student's/Patient's Doctor/Clinic					Telephone Number		
Name of Student's/Patient Dentist					Telephone Number		
Insurance <input type="checkbox"/> Medicaid <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> HAP <input type="checkbox"/> Total <input type="checkbox"/> Midwest <input type="checkbox"/> Great Lakes <input type="checkbox"/> Molina <input type="checkbox"/> Other: _____							
Identification Number on Card		Policy Number		Group Number		Coverage Code	
Member Name (parent/guardian)		Birth Date		Relationship to Student/Patient			
Member Employer (parent/guardian)				Employer's Address			

I have read this Parental Consent for Medical Treatment Form and understand the services available through the school-based health center. I consent to all of the following:

- The above named student/patient may receive all services listed on the back of this form at the South Redford School Based Health Center located within Pierce Middle School.
- The South Redford School Based Health Center may use my child's health information for administrative or operational purposes. My child will not be identified in any data or reports.
- The South Redford School Based Health Center may share health care information with other Botsford facilities for the purposes of continuity and coordination of care.
- South Redford School Based Health Center may release information regarding treatment to third party payers or others for the purpose of receiving payment for services.
- Both the South Redford School Based Health Center and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care.
- The South Redford School Based Health Center may obtain a copy of the above named student's/patient's immunization record from the student's/patient's school office, primary care provider's office, and/or local health department.

By signing this consent form, I certify that I am the parent/legal guardian of the student/patient named above. I understand that my consent will remain valid for the duration of my child's eligibility at the health center. Annual updates of my student's health history and insurance information will be requested. I understand that I may withdraw my consent for services upon written notice to the South Redford School Based Health Center at any time.

I acknowledge receiving a copy of the Botsford Health Care Privacy Notice.

Signature of Parent/Guardian

Date

STUDENT/PATIENT MEDICAL HISTORY:

Please check **Yes or No** for each condition listed below

Nosebleeds	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney/Bladder/Urine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent sore throats	<input type="checkbox"/> Yes <input type="checkbox"/> No	Eczema/Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Taking daily medication(s)	* <input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension (high blood pressure)	<input type="checkbox"/> Yes <input type="checkbox"/> No	*Name of medication(s), dosage & directions (i.e. albuterol inhaler)	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Shortness of breath/Trouble breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Headaches/Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Seizure (epilepsy)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Anxiety/Depression/Mental Illness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medication allergies (type: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD (attention deficit disorder)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Food allergies (type: _____)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (blood sugar problems)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies (hay fever, dust, pollen, pets, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell disease or trait	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bee sting allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia (low iron blood count)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgeries (i.e. tonsils, ear tubes, hernia, appendix)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Stomach problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type:	
Menstrual problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Overnight Hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No
Painful joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Why:	
Backaches	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Other health problems:			

FAMILY MEDICAL HISTORY:

Please check below if any of your child's relatives (i.e., mother, father, sister, brother, aunt, uncle, grandparents) have had any of the following illnesses and **note what relative had them.**

	Relative		Relative
<input type="checkbox"/> Heart problems		<input type="checkbox"/> Cancer	
<input type="checkbox"/> Cholesterol		<input type="checkbox"/> Diabetes (high blood sugar)	
<input type="checkbox"/> High Blood Pressure		<input type="checkbox"/> Anxiety/Depression/Mental Illness	
<input type="checkbox"/> Stroke		<input type="checkbox"/> Seizures	
<input type="checkbox"/> Asthma/Emphysema/Bronchitis		<input type="checkbox"/> Kidney	
<input type="checkbox"/> Death under age 50 (cause: _____)		<input type="checkbox"/> Other (describe: _____)	
<input type="checkbox"/> Sickle Cell Anemia/Blood problems		<input type="checkbox"/> Other (describe: _____)	

Services provided at the South Redford School Based Health Center

Parental consent is required for the following services provided to students/patients under the age of 18:

- Physical exams for school, sports, and camp
- Treatment for acute & chronic illness & injuries
- Vision/hearing screenings and follow-up
- Obesity Screening & Education
- Nutrition Education & Counseling
- Oral/dental screening and follow-up
- Immunizations
- Basic laboratory services & tests
- Administration of medication
- Individual, group, family, and community education
- Oral/dental screening and follow-up
- Dental cleanings & sealants (dependent on program availability)

Current Michigan Law allows for confidential services to mature minors in these areas:

- Gynecological services
- Pregnancy testing and referrals
- Sexually transmitted disease education, screenings, treatment, and counseling
- HIV education, screening and referrals
- Physical/sexual abuse education, counseling and referrals
- Crisis Intervention
- Substance abuse education, counseling and referrals
- Mental health education, assessment, counseling and referrals
- Referrals for specialty services

PARENTAL CONSENT IS NOT NEEDED FOR CRISIS INTERVENTION AND EMERGENCY CARE

LIMITATION OF SERVICES

- **NO** birth control pills or devices are dispensed or prescribed at **ANY** health center located on school property.
- **NO** abortion counseling, referrals or services are provided at **ANY** school-based/linked health center.