BOTSFORD HOSPITAL

# South Redford School Based Health Center
# Parental Consent for Medical Treatment
***(Please read and complete)***

Building Brighter Futures
South Redford Schools

| Student/Patient Name | Birth Date | Age | Male ☐ Female ☐ | Grade | Homeroom | School |
|---|---|---|---|---|---|---|
| | | | | | | |

**Race (Optional):** ☐ Black or African American ☐ White ☐ Native Hawaiian ☐ Arab American ☐ American Indian/Alaska Native ☐ Asian ☐ Other Pacific Islander ☐ Choose not to Report

**Ethnicity (Optional):** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ 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**
☐ Medicaid ☐ Blue Cross/Blue Shield ☐ HAP ☐ Total ☐ Midwest ☐ Great Lakes ☐ Molina ☐ 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 | ☐ Yes ☐ No | Kidney/Bladder/Urine problems | ☐ Yes ☐ No |
| Frequent sore throats | ☐ Yes ☐ No | Eczema/Rashes | ☐ Yes ☐ No |
| Heart problems | ☐ Yes ☐ No | Taking daily medication(s) * | ☐ Yes ☐ No |
| Hypertension (high blood pressure) | ☐ Yes ☐ No | ***Name of medication(s), dosage & directions (i.e. albuterol inhaler)** | |
| Asthma | ☐ Yes ☐ No | | |
| Shortness of breath/Trouble breathing | ☐ Yes ☐ No | | |
| Pneumonia | ☐ Yes ☐ No | ***Condition for medication(s) (i.e., asthma, allergies, ADHD, eczema)** | |
| Headaches/Migraines | ☐ Yes ☐ No | | |
| Seizure (epilepsy) | ☐ Yes ☐ No | | |
| Fainting | ☐ Yes ☐ No | | |
| Anxiety/Depression/Mental Illness | ☐ Yes ☐ No | Medication allergies (type: ) | ☐ Yes ☐ No |
| ADD/ADHD (attention deficit disorder) | ☐ Yes ☐ No | Food allergies (type: ) | ☐ Yes ☐ No |
| Diabetes (blood sugar problems) | ☐ Yes ☐ No | Allergies (hay fever, dust, pollen, pets, etc.) | ☐ Yes ☐ No |
| Sickle cell disease or trait | ☐ Yes ☐ No | Bee sting allergies | ☐ Yes ☐ No |
| Anemia (low iron blood count) | ☐ Yes ☐ No | Surgeries (i.e. tonsils, ear tubes, hernia, appendix) | ☐ Yes ☐ No |
| Stomach problems | ☐ Yes ☐ No | Type: | |
| Menstrual problems | ☐ Yes ☐ No | Overnight Hospitalizations | ☐ Yes ☐ No |
| Painful joints | ☐ Yes ☐ No | Why: | |
| Backaches | ☐ Yes ☐ 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 |
|---|---|---|---|
| ☐ Heart problems | | ☐ Cancer | |
| ☐ Cholesterol | | ☐ Diabetes (high blood sugar) | |
| ☐ High Blood Pressure | | ☐ Anxiety/Depression/Mental Illness | |
| ☐ Stroke | | ☐ Seizures | |
| ☐ Asthma/Emphysema/Bronchitis | | ☐ Kidney | |
| ☐ Death under age 50 (cause: ) | | ☐ Other (describe: ) | |
| ☐ Sickle Cell Anemia/Blood problems | | ☐ 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.