



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							
Parental Consent is required for the following services provided to patients under the age of 18: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <ul style="list-style-type: none"> • 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 </div> <div style="width: 50%;"> <ul style="list-style-type: none"> • Physical exams for school, sports, camp and work • Vision/hearing screenings and follow up • Immunizations • Medication administration • Referrals for specialty services </div> </div>							
Current Michigan law allows for confidential services to minors aged 12 and up. <u>Parental consent is not required for:</u> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <ul style="list-style-type: none"> • 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) </div> <div style="width: 50%;"> <ul style="list-style-type: none"> • Sexually Transmitted Infection screenings, treatment/counseling • Physical/sexual abuse counseling and referrals • Crisis intervention and emergency care </div> </div>							
Services Not Provided at the School-Based Health Center							
Per Michigan Law: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <ul style="list-style-type: none"> • Birth control pills and contraceptive devices are not dispensed or prescribed on school premises </div> <div style="width: 50%;"> <ul style="list-style-type: none"> • Abortion counseling, referrals, or services are not provided </div> </div>							
Parent/Guardian Consent							
I consent to the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> ○ 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	<input type="checkbox"/> Female <input type="checkbox"/> Male	Current Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Transgender Male (Female to male) <input type="checkbox"/> Transgender Female (Male to female)	<input type="checkbox"/> Choose not to disclose <input type="checkbox"/> Other: _____
Sexual Orientation	<input type="checkbox"/> Straight/Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't Know <input type="checkbox"/> Choose not to disclose				
Race	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> White or Caucasian <input type="checkbox"/> More than one race <input type="checkbox"/> Other: _____				
Ethnicity	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Arab <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> More than one ethnicity		Preferred Language	<input type="checkbox"/> English <input type="checkbox"/> Arabic <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Living Situation	<input type="checkbox"/> Not Homeless (Family owns or rents a home/apartment) <input type="checkbox"/> Homeless		Are you worried about losing your housing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Student's Primary Care Doctor			Phone #:		
Student's Dentist			Phone #		
Date of Last Physical	____/____/____		<input type="checkbox"/> 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:

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

<input type="checkbox"/> Asthma	Who: _____	<input type="checkbox"/> Hypertension	Who: _____
<input type="checkbox"/> Anxiety, depression, or other mental illness	Who: _____	<input type="checkbox"/> High Cholesterol	Who: _____
<input type="checkbox"/> Cancer	Who: _____	<input type="checkbox"/> Kidney Problems	Who: _____
<input type="checkbox"/> Death under age 50	Who: _____	<input type="checkbox"/> Seizures	Who: _____
<input type="checkbox"/> Diabetes	Who: _____	<input type="checkbox"/> Sickle Cell Anemia	Who: _____
<input type="checkbox"/> Heart Problems	Who: _____	<input type="checkbox"/> Stroke	Who: _____