Parent/Guardian Consent Form
Mental Health Services
NICE Community School District
300 Westwood Drive, Ishpeming, MI 49849
Phone: 906-485-1023
www.mqthealth.org

Please read and complete FRONT and BACK of this form. This form is needed for each student to be seen in the Clinic. Please use Ink

Student name (Last Name, First Name, Middle Initial):	Date of Birth:	Age:	Sex: Male☐ Female☐	Grade:
Address: City: Zip:		Student telephone:	Today's Date:	
Name of student's employer		Your estimate of student's annual income		

Race/Ethnicity (Optional):
☐Black or African American ☐White ☐Hispanic/Latino ☐American Indian/Alaskan Native ☐Arab ☐Asian ☐Native Hawaiian/Pacific Islander

Parent/Guardian (Last Name, First Name, Middle Initial):	Relationship to Student:
Address (if different than child):	Parent E-Mail Address:

Home phone:	Cell Phone:	Work Phone:
Name of Emergency Contact:	Relationship to Student:	Telephone #:
Name of Student's Physician/Clinic:	Date of last annual exam (Well Child):	
Name of Student's Dentist/Clinic:	Date of last exam:	

Insurance:
☐Medicaid ☐Blue Cross/Blue Shield ☐MI Child ☐TRICARE ☐Other:_____ ☐No insurance

Policy Holder Name (Last Name, First Name, Middle Initial):	Date of Birth:	Relationship to Student:
Address: City: State: Zip:		
Policy ID #:	Group #:	

I have been fully informed and I give my consent to the following:

- The NICE Community School District may release information to the Marquette County Health Department (MCHD) for the purpose of receiving treatment and the Marquette County Health Department may release information to the NICE Community School District for the purpose of educational case management.
- The above named student may receive all services listed on the back of this form at the MCHD Mental Health Clinic. If I am requesting any changes to this consent, I will submit the changes in writing to the Clinic.
- Both the Marquette County Health Department and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- Completion of a risk assessment by the above named student.
- This consent form will remain active and on file at the MCHD Mental Health Clinic while my student is enrolled in the NICE Community School District unless rescinded by me in writing.
- The Marquette County Health Department to bill my health insurance carrier for services provided to my child. The parent/guardian may be responsible for copay and deductible amounts.

I understand that the Marquette County Health Department is in compliance with all HIPAA laws and regulations.
The Privacy Notice is available at the clinic or online at: www.mqthealth.org.
I understand that I have the right to refuse to sign this consent form; however, my child will not be able to be seen at the clinic.

Signature of Parent/Guardian: X _____

Printed name: _____ Date: _____

STUDENT MEDICAL HISTORY (OPTIONAL):

Taking daily medication(s) ☐Yes ☐No ***Name of medication(s) and Dosage *Condition for medication(s)	Food Allergies/Sensitivities: (list below) ☐Yes ☐No
Medication Allergies: (list below)	Surgeries (type:_____) ☐Yes ☐No Overnight Hospitalizations (why) ☐Yes ☐No

FAMILY MEDICAL HISTORY (OPTIONAL):
Please check below if any of your child's relatives (mother, father, sister, brother, aunt, uncle, grandparents) have had any of the Following illnesses and note who had them.

☐Major Depression	
☐Bipolar Disorder	
☐Anxiety Disorder	

Services provided at the Marquette County Health Department Mental Health Clinic:

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
• Individual, group, family, and community education • Referrals for specialty services	• Physical/sexual abuse counseling and referrals • Crisis intervention • Substance abuse education, counseling, and referrals • Mental health assessment, counseling, and referrals

Check the appropriate box:

☐ I would like to schedule an appointment for my child. Please call me to schedule an appointment at this phone number _____.

☐ Please keep this consent form for future use, if needed.

☐ I consent to the use of telehealth services by video or telephone, as needed, for my child.

Please complete and return to your school office at your earliest convenience.
You may also mail your form to:

Jamie Dieterle, LMSW, CAADC
Westwood High School
300 Westwood Drive
Ishpeming, MI 49849