



# HORNET HEALTH CENTER

Pellston High School  
172 Park St., Pellston, MI 49769  
(231) 539-8550 Fax (231) 539-8616



The Hornet Health Center is a school-based health center of the Health Department of Northwest Michigan supported through a grant from the Michigan Departments of Community Health and Education in collaboration with Pellston Public Schools. It is located in Pellston Middle/High School. The health center serves persons age 5 to 21 who live in Emmet, Cheboygan County and surrounding communities, and their children.

Health center services include: mental health services (individual, family and group counseling); and medical services, including: primary care; treatment for illness and injuries; physical exams for school, sports, and camp; basic laboratory services and tests; referral for specialty health services; student health assessment, education, and risk reduction programs; chronic disease management; sexually transmitted disease testing and prevention; HIV counseling and testing; immunizations; medication administration; vision/hearing screenings; dental care; and Medicaid Outreach and enrollment.

Student Name		Birth Date	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	Grade	<input type="checkbox"/> PES <input type="checkbox"/> PMS <input type="checkbox"/> PHS <input type="checkbox"/> Other
Street Address		Mailing Address (PO Box)		City	Zip Code	Home Phone Number
Race (Optional)	<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian	<input type="checkbox"/> American Indian	<input type="checkbox"/> More Than One	<input type="checkbox"/> Other
Ethnicity (Optional)	<input type="checkbox"/> Non-Arabic/Non-Hispanic		<input type="checkbox"/> Hispanic	<input type="checkbox"/> Arabic		
Mother Last Name	Mother First Name		Father Last Name		Father First Name	
Guardian Last Name (if different than mother/father)		Guardian First Name (if different than mother/father)			Relationship To Student	
Daytime Telephone Number		Evening Telephone Number		Cell Phone/Pager		E-Mail Address
Name Of Emergency Contact (other than parent/guardian)			Relationship		Telephone Number	
Name of Student's Physician or Clinic		Physician or Clinic Telephone Number		Name of Student's Dentist		
<b>HEALTH INSURANCE:</b>						
<input type="checkbox"/> None (uninsured) Please contact me about MIChild/Healthy Kids health insurance for my child. <input type="checkbox"/> Yes <input type="checkbox"/> No						
<input type="checkbox"/> Medicaid/Medicaid HMO: (Check one) <input type="checkbox"/> Mihealth (Medicaid) <input type="checkbox"/> Priority Health <input type="checkbox"/> CareSource <input type="checkbox"/> Other Medicaid HMO: _____						
Mihealth Card Number (student's) _____						
OR						
<input type="checkbox"/> Blue Cross/Blue Shield	Insurance Policy Number		Name of Policy Holder		Does your insurance pay for immunizations? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Other Insurance: _____	Insurance Group Number		Birth Date of Policy Holder		Relationship To Student	

### Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor children for services at the health center. Students without a consent form signed by a parent/guardian on file will not be seen at the Hornet Health Center, except for a student's first visit to the health center, when staff will telephone parent/guardian for verbal consent on a one-time-only basis. The only other exceptions, according to Michigan law are: emergencies threatening life or limb; substance abuse services; HIV counseling and testing; sexually transmitted infection treatment; and-- for minors 14 and older--mental health services. People who are age 18 or older, legally emancipated, legally married, under court order, in the presence of a law officer when the parent cannot be promptly located, and/or members of the US Armed Forces provide consent for services themselves.

By signing this form I certify that I am the legal guardian and legal custodian of \_\_\_\_\_  
Student's name

### Consent for Immunizations

I understand my/my child's immunization (shot) records from Pellston Public School and the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that I/my child needs a shot, I give my permission for it to be given at the Hornet Health Center, and I give permission that the administration of the vaccine be recorded in the Michigan Childhood Immunization Registry. I understand a letter with the needed shot and Vaccine Information Sheet(s) will be sent home for my review at least 1 week before the immunization is planned to be given. If I do not want the shot given to me/my child, I need to call or write to the Hornet Health Center before the planned shot day.

\_\_\_\_\_  
Signature of Parent/Guardian/Client 18 years and older

\_\_\_\_\_  
Date

### Consent for Services

- I have reviewed and understand the services offered by the health center.
- For Parents/Guardians - I give consent for my child to receive the services described above until age 18.
- I understand it is not necessary to renew my consent yearly. I further authorize the Hornet Health Center to release information regarding treatment to the following: Hornet Health Center staff and its subcontractors, and other health care providers when needed to coordinate care; 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 received a copy of the Health Department's Notice of Privacy Practices brochure.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I give consent for my/my child's height and weight to be entered into the Michigan Childhood Immunization Registry (MCIR)

\_\_\_\_\_  
Signature of Parent/Guardian/Client 18 years and older

\_\_\_\_\_  
Date

*Please complete the other side of this form.*

Parent/Guardian Signature needed here.

*Please complete the other side of this form.*

**HORNET HEALTH CENTER  
CLIENT AND FAMILY MEDICAL HISTORY FORM**

**CLIENT MEDICAL HISTORY:**

Bee sting allergies <input type="checkbox"/> Yes <input type="checkbox"/> No	Has your child had any problems with childhood vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No Explain: _____	Overnight Hospitalizations <input type="checkbox"/> Yes <input type="checkbox"/> No Reason: _____
Medication allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	Has your child had chickenpox vaccines? <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____
Food allergies (i.e. eggs, yeast) <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	Has your child had chickenpox disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>If yes, please provide approximate month and year</b> _____	Daily medications <input type="checkbox"/> Yes <input type="checkbox"/> No Name(s): _____
Allergies, i.e. hay fever, dust, pollen <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No	Conditions for medications <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure (epilepsy) <input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes (high blood sugar) <input type="checkbox"/> Yes <input type="checkbox"/> No	Painful Joints <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia (low iron/blood count) <input type="checkbox"/> Yes <input type="checkbox"/> No
Eczema/Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No	Pounding of Heart <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD / ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Urination <input type="checkbox"/> Yes <input type="checkbox"/> No	Bladder problems <input type="checkbox"/> Yes <input type="checkbox"/> No
Hypertension (high blood pressure) <input type="checkbox"/> Yes <input type="checkbox"/> No	Nosebleeds <input type="checkbox"/> Yes <input type="checkbox"/> No	Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle cell (trait or disease) <input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Sore Throats <input type="checkbox"/> Yes <input type="checkbox"/> No	Other health problems <input type="checkbox"/> Yes <input type="checkbox"/> No _____
Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No	Backaches <input type="checkbox"/> Yes <input type="checkbox"/> No	_____

**FAMILY MEDICAL HISTORY:**

Please check the diseases/conditions in child's family	Please note which relative has/had this condition (Mother, father, brother/sister, grandparent, aunt/uncle)
<input type="checkbox"/> Heart problems	
<input type="checkbox"/> High cholesterol	
<input type="checkbox"/> High blood pressure	
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	
<input type="checkbox"/> Death under age 50 (Cause: _____)	
<input type="checkbox"/> Cancer	
<input type="checkbox"/> Diabetes (high blood sugar)	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Seizures	
<input type="checkbox"/> Kidney	
<input type="checkbox"/> Sickle Cell Anemia/Blood problems	
<input type="checkbox"/> Addiction	
<input type="checkbox"/> Other	

1. Would you like information from our staff regarding:	
Options for health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a health care provider (doctor or nurse practitioner)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you or any of your family members have anything you would like to discuss with the Therapist?	
Do you have concerns about the emotional well being of yourself/your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you concerned about your income meeting the basic needs of your family?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Please circle your concerns:**    Food    Clothing    Housing    Paying for bills for heat and water    Transportation to medical or school appointments

*If you answered YES to any of the above, a member of our staff will contact you*

**Is there anything else you would like us to know about your child?**

**Consent to Photograph**

I, the undersigned, authorize photographs to be taken of me/my child for the health center. I further authorize Health Department of Northwest Michigan to use any such photographs for the purpose of illustrations or publications.

**Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Please sign and date the other side of this form and return to the  
HORNET HEALTH CENTER, 172 PARK ST., PELLSTON MI 49769  
For questions or additional information, telephone the health center at (231) 539-8550.*

Reviewed with client \_\_\_\_\_  
Initials \_\_\_\_\_ Date \_\_\_\_\_