HEALTH DEPARTMENT of Northwest Michigan
1-800-432-4121

CHILD AND ADOLESCENT HEALTH PROGRAM
Hornet Health Center Parent/Guardian Consent for Services

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School

Street Address	Mailing Address (PO Box)	City	Zip Code	Home Phone Number

Race (Optional) ❒ White ❒ Black ❒Asian ❒American Indian ❒ More Than One ❒ Other

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒Hispanic ❒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

Name of Pharmacy	Pharmacy Telephone Number

HEALTH INSURANCE (Please complete all information)

❒ None (uninsured) Please contact me about MIChild/Healthy Kids health insurance for my child. ❒ Yes ❒ No

❒ Medicaid/Medicaid Health Plan Child's Card Number _____

❒ Blue Cross/Blue Shield
❒ Blue Care Network
❒ Priority Health
❒ TriCare
❒ Other:_____

Name of Policy Holder _____
Insurance Policy Number _____
Insurance Group Number _____
Birth Date of Policy Holder _____
Relationship of Policy Holder to child? _____
Does your insurance pay for immunizations? ❒ Yes ❒ No

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

Please check 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?

HORNET HEALTH CENTER
Pellston Middle/High School
172 Park St., Pellston, MI 49769
(231) 539-8550
Fax (231) 539-8616

Child/Adolescent Name

PARENT/GUARDIAN CONSENT

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, except for a student's first visit to the Hornet 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; pregnancy testing, substance abuse services; family planning counseling 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.

Services not provided include prescribing medications, dispensing birth control, provision of abortion counseling or referrals, and dispensing of medications other than those covered under standing orders. Family planning drugs and/or devices *will not* be prescribed, dispensed or distributed and no abortion counseling, referrals or services will be provided.

Parent/Guardian Signature needed here.

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

Immunization Consent

Consent for Immunizations

I understand my/my child's immunization (shot) records from 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 Child and Adolescent 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. My child may come to the appointment without me for vaccine administration. If I do not want the shot given to me/my child, I need to call or write to the Child and Adolescent Health Center before the planned shot day.

_____ _____

Signature of Parent/Guardian/Client 18 years and older **Date**

Consent for Services

Wellness Program services include: mental health services (individual, family and group counseling) and medical services, including school nursing assessment and care, minor injury treatment, medication administration, coordination of chronic disease management in partnership with the school and primary care provider, basic laboratory services and tests and sexually transmitted infection testing and prevention, immunizations assessment, referrals to establish primary care and oral health care, nursing and mental health provider assessment of risk behaviors, and acute care services through the use of telemedicine equipment.

- I have reviewed and understand the services offered by the Wellness Program.
- 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: Wellness Program staff and its subcontractors, and other health care providers, including the primary care provider, 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 understand that if needed services are beyond the scope of practice for a nurse, telemedicine technology could be used to connect with a nurse practitioner to work together for a diagnosis and treatment plan, which could include the prescribing of medications.
- I understand that if needed, telehealth technology may be used for the provision of counseling services by a mental health professional.

_____ _____

Signature of Parent/Guardian/Client 18 years and older Date

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:** _____

Child/Adolescent Name

CLIENT AND FAMILY HISTORY FORM

Allergy (Medicine, food, environment)	Reaction/Severity

Medication/Prescription/Vitamins	Dose	Frequency	Route	Who prescribed this medication?	Reason

Last Complete Physical Exam _____ **Last Dental Exam** _____

CLIENT AND FAMILY MEDICAL HISTORY – Please check which family member has/had these conditions.

Disease/Condition	Client	Mother	Father	Sibling	Grand-parent	Other	Comment
Addiction – Type:	☐	☐	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	☐	☐	☐	
Birth defects	☐	☐	☐	☐	☐	☐	
Blood/Bleeding disorders	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Death Under Age 50 - Cause:	☐	☐	☐	☐	☐	☐	
Developmental Disability	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Eating disorders/Special diet/Pica	☐	☐	☐	☐	☐	☐	
Endocrine/Thyroid	☐	☐	☐	☐	☐	☐	
Gastrointestinal disorders	☐	☐	☐	☐	☐	☐	
Genetic abnormalities	☐	☐	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	☐	☐	
Hepatitis/Liver disease	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	
Immune Suppression/HIV/AIDS	☐	☐	☐	☐	☐	☐	
Kidney/Urinary disease	☐	☐	☐	☐	☐	☐	
Mental Retardation/Learning Disorder	☐	☐	☐	☐	☐	☐	
Musculoskeletal disorders	☐	☐	☐	☐	☐	☐	
Neurologic disorder/Seizures	☐	☐	☐	☐	☐	☐	
Obesity BMI > 95%	☐	☐	☐	☐	☐	☐	
Overweight BMI 85%-94%	☐	☐	☐	☐	☐	☐	
Physical/Sexual/Verbal/Domestic Abuse	☐	☐	☐	☐	☐	☐	
Psychiatricdisorders/ Depression/Suicide - Specify	☐	☐	☐	☐	☐	☐	
Pulmonary/TB/Asthma - Specify	☐	☐	☐	☐	☐	☐	
Skin disorder - Specify	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Source of family history	☐	☐	☐	☐	☐	☐	
Unknown family history	☐	☐	☐	☐	☐	☐	
Other relevant patient or family history	☐	☐	☐	☐	☐	☐	

CLIENT HISTORY – Please check if your child has had/does have any of these conditions.

Condition	Date of Onset	Comment
ADD/ADHD		
Anaphylaxis		
Autism		
Back injuries		

Child/Adolescent Name

CLIENT HISTORY (cont.)

Backaches		
Bladder conditions		
Fainting		
Food allergies - Specify		
Frequent sore throat		
Frequent urination		
Problems with head, eyes, ears, nose, or throat		
Headaches		
Hearing problems		
Heart abnormalities/Murmurs		
Hernias		
Mental Health Conditions		
Nosebleeds		
Painful joints		
Pneumonia		
Problems with childhood vaccines		
Psycho-Social problems		
Rheumatic Fever		
Seasonal Allergies		
Secondhand smoke		
Shortness of breath		
Skin conditions		
Vision problems		
Other:		
Substance Use		
Alcohol		
Chew/Tobacco		
Cigarettes		
Cocaine		
Marijuana		
Other:		
Surgery/Hospitalizations		
Adenoids removed		
Appendectomy		
Asthma Exacerbation		
Ear tubes		
Fracture		
Head injury/Concussion		
Heart Surgery		
Premature birth		
Tonsilectomy		
Trauma		
Other:		

Reviewed with client _____ _____
Initials Date

Please return completed form to:

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The Child and Adolescent Health Program is operated by the Health Department of Northwest Michigan,
with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.