HACKLEY COMMUNITY CARE
SCHOOL BASED HEALTH

Parental Consent and Health History Form

Phone Number
231.733.6868
After Hours Number
231.737.1335

Serving ages 5-21

Patient/Student Information

This Parental Consent will remain valid until revoked in writing by parent/guardian.

Name: First ______ Middle ______ Last ______ DOB ______ Current School District ______

CHECK THE BOXES BELOW THAT DESCRIBE:
SEX ☐ MALE ☐ FEMALE ☐ CHOOSE NOT TO DISCLOSE
RACE ☐ AFRICAN AMERICAN ☐ WHITE/CAUCASIAN ☐ MORE THAN ONE RACE ☐ PACIFIC ISLANDER ☐ NATIVE HAWAIIAN ☐ ASIAN
☐ NATIVE AMERICAN/ALASKAN NATIVE ☐ OTHER **AND ETHINICITY** ☐ HISPANIC ☐ NON HISPANIC

Cell Phone Number: ______________________________
(Patient/student cell number, if they have one)
Email address: ______________________@________________
(personal email preferred, but school email can be used)

Consent for Services

Hackley Community Care (HCC) School Based Health (SBH) services may include: ***mental health services** (treatment, assessment, individual, family and group counseling); **dental services** (preventative, restorative, and surgical); 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; nursing services; and Medicaid Outreach and enrollment. These services may be in-person or via **telehealth services** (telephone consultations, video conferencing, transmission of still images, e-health technologies, patient portals, texting, email and remote patient monitoring and involves the communication of patient medical/mental health information in an electronic or technology-assisted format).

- I have reviewed and understand the services offered by HCC SBH. 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 understand I may withdraw my consent for services at any time upon written notice. Consent will be valid at all HCC SBH sites. Minor children without a signed consent form on file will not be seen. Exceptions to this include: a one-time verbal consent by phone from parent/guardian; an emergency threatening life or limb; students who are legally emancipated; students who are legally married; under court-order; in the presence of a law officer when the parent cannot be promptly located; members of the U.S. Armed Forces; and ***minor confidential services.**

- I understand my child's immunization (shot) records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that my child needs an immunization and parent is not present a Vaccine Information Sheet(s) will be sent home with my child and consent must be signed and returned before an immunization is administered.

- I understand that dental treatment may be provided at one of our mobile dental sites. I understand that this treatment can also be obtained at my child's dental home and that obtaining duplicate services may affect benefits that my child receives from private insurance, a state or federal program, or third-party provider of dental benefits. I understand that certain dental procedures may require additional consent forms and signatures in person by parent/guardian.

- I understand that testing for blood borne diseases, including HIV/AIDS, may be performed without separate written consent in the event that a staff member receives a cut or exposure to my child's blood or body fluids.

- I understand that HCC SBH has joint medical and mental health medical records that can be accessed to coordinate care.

- I understand HCC SBH staff will release information regarding treatment to the following: staff and its subcontractors; other health care providers, including primary care physicians, when needed to coordinate care; school staff, including the athletic trainer, when needed to coordinate services at school; and third-party payers when needed for payment of services.

- I understand that telehealth services may limit my healthcare provider's ability to fully diagnose a condition or disease and the School Based Health provider is not responsible for breaches of confidentiality caused by an independent third party or by me or my child.

- I understand that HCC SBH will bill insurance (when/if available) for services rendered and that some co-pays may apply. Telehealth visits are billable and telehealth billing information is collected in the same manner as a regular office visit.

- I understand that HCC SBH staff will have access to school records, to include the Power School system. Access to this information may include demographic data, class schedules and attendance records for my child to coordinate appointments and absences related to school program services. Staff will follow all Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) laws related to such information.

- I understand that HCC SBH services are in compliance with all HIPAA laws and regulations. The full privacy practice is available for me to have or review at any of the SBH locations or on the HCC website (www.hackleycommunitycare.org). I understand a copy of the Notice of HIPAA Privacy Practices can be mailed to me at my request.

- I understand that an updated Parental Consent form may be requested as necessary to update my child's information for our records.

______________________________________ ______________
Signature of Parent/Guardian OR Patient 18 years and older **Date**

*Note: In accordance with Michigan legal requirements, parental consent is *not* required for outpatient mental health services for individuals age 14 and older, for minors to receive a diagnosis/ medical treatment for a venereal disease or HIV, or a diagnosis of pregnancy or related prenatal care. This District will provide these services in accordance with MCLA (Michigan Complied Laws Annotated) 333.9132, 333.5127, 333.1707

Please Complete the Back of This Form

Patient/Student Medical History

Name of your doctor & office:_________________________ Phone:_______________ Last visit:_______________
Preferred Pharmacy: ____
Have you seen a dentist in the last 12 months? ❑ YES ❑ NO   Name & Phone #: _______________________

Patient/Student History (Please Check All that Apply):

❑ADD/ADHD or Learning Disability (school IEP?)	❑Drug Abuse (illegal or prescription)	❑Respiratory Problems (sleep apnea/snoring/cystic fibrosis)
❑Alcohol abuse	❑Eye Problems (previous surgery/ glaucoma/ impaired vision)	❑Scoliosis
❑Allergies (drug or environmental)	❑Frequent Headaches or Migraines	❑Sexually Transmitted Infections (HIV/AIDS/ gonorrhea/ chlamydia/trichomonas)
❑Anemia or Bleeding Disorder (hemophilia/bruise easily/excessive bleeding)	❑Hearing problems	❑Sickle Cell disease or trait
❑Asthma or Shortness of Breath	❑Heart Problems (high blood pressure/ congenital heart defect/ heart murmur/ rheumatic fever/irregular heartbeat)	❑Skin problems (acne, rash)
❑Autism/Autism Spectrum Disorder	❑Infectious Disease (recurrent sinusitis/ measles/mumps/mononucleosis/pneumonia/meningitis/scarlet fever/chicken pox/TB/strep)	❑Speech Problems
❑Bladder or Kidney Problems/Infections	❑Liver Problems (hepatitis/jaundice)	❑Sports Injuries/Broken Bones/Injury to Face or Teeth
❑Cancer (chemotherapy/radiation therapy/bone marrow or organ transplant)	❑Mood Difficulties (depression/anxiety/suicidal thoughts/self-harm/eating disorder)	❑Thyroid Problems
❑Diabetes	❑Neurological Problems (cerebral palsy/seizures/brain injury)	❑Tobacco use (cigarettes/vaping/e-cig/chewing tobacco)
❑Digestive Problems (vomiting/ heartburn/acid reflux)	❑Premature Birth or Birth defects	❑Other

Provide Details Here: ____
____

Please list any medications or vitamins (prescription or over the counter) that are currently being taken and reason for taking them:
____
____

Please check if allergic to any of the following:
❑ Medications (please list)____
❑ Latex ❑ Dyes_______________ ❑ Metals____________ ❑ Foods_________________ ❑ Other_________________
Have you ever had any surgeries? ❑ YES ❑ NO Age(s) & Reason: _______________________
Have you ever been hospitalized? ❑ YES ❑ NO Age(s) & Reason: _______________________
Do you have any health concerns? ❑YES ❑ NO Explain:_______________________
Females Only: Are you or could you be pregnant? ❑ YES ❑ NO Are you using any type of birth control? ❑ YES ❑ NO

Family History (Please Check All that Apply):

❑Alcohol or Drug Abuse	❑High Cholesterol	❑Stomach Problems
❑Arthritis	❑Kidney Disease	❑Thyroid Disease
❑Birth Defects	❑Learning Disability	❑Tobacco Use
❑Cancer (breast/colon/other)	❑Lung Disease (COPD/asthma/other)	❑Tuberculosis
❑Diabetes	❑Mood Problems (same as above)	❑Other
❑Heart Disease (premature death/hypertension)	❑Seizures	

Parent/Guardian Information (If not a parent, we may require paperwork/releases)

Parent/Guardian_____________________ DOB____________ Phone #____________ Work #____________
Address_________________________________ Email address_______________________
Relationship to patient/student _______________________________

Parent/Guardian_____________________ DOB____________ Phone #____________ Work #____________
Address_________________________________ Email address_______________________
Relationship to patient/student _______________________________

Patient Medical/Dental Insurance Information

***Medical/Health Insurance:**
☐Uninsured ☐Medicaid______________ ☐Private______________ Policy Holder Name ____________________
Policy Holder DOB________________ Policy Holder's Employer_______________________________
Policy Number______________________________ Group Number__________________
***Dental Insurance: *This is a different carrier than your medical insurance. Most dental insurance carriers do not distribute cards**
☐Uninsured ☐Medicaid______________ ☐Private______________ Policy Holder Name____________________
Policy Holder DOB________________ Policy Holder's Employer_______________________________
Member ID Number___________________________ Group Number__________________

*****If you or your child(ren) need help applying for Medicaid or our Sliding Fee Scale, please contact one of our school based health staff for assistance*****

For Office Use Only:
Provider's Initials/ Date Reviewed: ______________________ Provider's Initials/ Date Reviewed: ______________________