School Based Health Centers Consents and Acknowledgements for Minor Child
(Operated by Mott Children's Health Center)
Centers located at:
Northwestern High School♦Beecher Middle/High School♦

Print Student's Full Name: _____ Date of birth: _____

Print Name of Parent/Guardian:_____ Date of birth: _____

I give my consent for the above named minor to receive mental health, medical, dental, counseling and treatment at a school based health center. These services may include: physicals, sick care, immunizations, health education and risk assessments. I understand that Michigan law does not require parental consent for treatment of drug abuse, alcoholism, sexually transmitted infections, pregnancy or contraception.

I understand that testing for blood borne diseases (including HIV/AIDS) may be performed upon a patient without a separate written consent in the event that a health care employee receives a cut or exposure to my child's blood or body fluids.

I give my permission to have the health center bill any insurance I have for services provided.

I understand that my child's picture may be taken for identification and protection purposes only, and will become a part of my/my child's record.

I give my permission to have my child complete classroom or health center surveys, which will be used to improve programs and services at the school, based health centers. I understand that my child's participation is voluntary and that he/she will not be identified in any way.

I acknowledge that I have received the Mott Children's Health Center Notice of Privacy Practices.

I give my consent to share health information with my child's medical provider and the Michigan Care Improvement Registry (MCIR) either verbally or written. We measure your child's height and weight and record that information in (MCIR) Body Mass Index (BMI) Growth Module. We use the resources and tools in the module to promote healthy weight and lifestyle habits for your child. Use of the module is optional for your child and you may decline this service. I understand that no information will be shared unless there is a valid reason for doing so.

I have read and understand this document and sign it freely and voluntarily.

_____
Date

_____
Parent/Guardian or Legal Representative of Minor or Patient is 18 or older

_____
Relationship to Minor

_____
Witness

PLEASE COMPLETE HEALTH HISTORY ON BACK OF THIS FORM!

Health History and Insurance Information

Patient Information:

Name: _____ DOB: _____ SS#: _____

Race: _____ Age:_____ Sex: M F Grade: _____

Address: _____ City: _____ Zip:_____

Day Time Phone:_____ Alternative phone: _____

Emergency Contact: _____ Phone: _____

Health History of Patient:

Allergies: (list all & describe reaction)_____

Past medical history:_____

List all medications your child is taking at the present time: _____

_____

Please check the box if your child has ever had the following health conditions:

Asthma Chickenpox: age _____ Seizures Diabetes Heart Problems
ADD/ADHD Depression/Bipolar Seasonal allergies Skin Problems
Other Health conditions/surgeries:_____

_____

Family history: (diabetes/heart/cancer/depression/high blood pressure for ex.)

_____

_____

Health Insurance Information:

Family Doctor:_____

Does your child have health insurance? Yes No

Name of Insurance Company:_____

Subscriber Name: _____ Subscriber/parent DOB: _____

Group #: _____ Contract #: _____