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

CHILD AND ADOLESCENT HEALTH PROGRAM
Parent/Guardian Consent for Services

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School

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

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

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

Parent/Guardian Last Name	Parent/Guardian First Name	Parent/Guardian Last Name	Parent/Guardian First Name

Daytime Telephone Number	Cell Phone	E-Mail Address

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

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 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; 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.

The health center does not provide abortion counseling, services, or referrals.

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

Consent for Services

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.

- 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 Child and Adolescent Health Center to release information regarding treatment to the following: 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 see back for additional information

Child/Adolescent 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**

Insurance Information

HEALTH INSURANCE (Please complete all information)

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

❒ **Medicaid/Medicaid HMO** **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**

Additional Information

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 circle your concerns: Food Clothing Housing Paying for bills for heat and water

Dentist Doctor Mental Health Needs Transportation to medical appointments or school

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

Please see back for additional information

Child/Adolescent Name

CLIENT AND FAMILY HISTORY FORM (Please write NA, if nothing to report)

Name of Student's Physician or Clinic	Physician or Clinic Telephone Number	Name of Student's Dentist
Name of Pharmacy		Pharmacy Telephone Number
Allergy (Medicine, food, environment, seasonal)		Reaction/Severity

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

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

Disease/Condition	Client	Mother	Father	Sibling	Grand-parent	Other	Comment
Addiction – Type:	☐	☐	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	☐	☐	
Asthma - Specify	☐	☐	☐	☐	☐	☐	
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	☐	☐	☐	☐	☐	☐	
Heart abnormalities/Murmurs	☐	☐	☐	☐	☐	☐	
Hepatitis/Liver disease	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	
Kidney/Urinary disease	☐	☐	☐	☐	☐	☐	
Learning Disorder	☐	☐	☐	☐	☐	☐	
Musculoskeletal disorders	☐	☐	☐	☐	☐	☐	
Neurologic disorder/Seizures	☐	☐	☐	☐	☐	☐	
Obesity/Overweight	☐	☐	☐	☐	☐	☐	
Physical/Sexual/Verbal/Domestic Abuse	☐	☐	☐	☐	☐	☐	
Psychiatric disorders/ Depression/Suicide - Specify	☐	☐	☐	☐	☐	☐	
Skin disorder - Specify	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	

Please see back for additional information

Child/Adolescent Name

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

Condition	Date of Onset	Comment
ADD/ADHD		
Anaphylaxis		
Autism		
Backaches/Back injury		
Fainting		
Frequent sore throat		
Frequent urination/Bladder conditions		
Problems with head, eyes, ears, nose, or throat		
Headaches		
Hearing problems		
Hernias		
Nosebleeds		
Pneumonia		
Problems with childhood vaccines		
Rheumatic Fever		
Shortness of breath		
Other:		
Substance Use/Exposure		
Alcohol		
Chew/Tobacco/Cigarettes/Vaping		
Cocaine		
Marijuana		
Secondhand smoke		
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:

☐ **IRONMEN HEALTH CENTER**
Mancelona Family Resource Center
205 Grove St., Mancelona, MI 49659
(231) 587-9840
Fax (231) 587-9846

☐ **GAYLORD BLUE DEVIL WELLNESS CENTER**
Gaylord High School
90 Livingston Blvd., Gaylord, MI 49735
(989) 732-6890
Fax (989) 705-1037

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.

Please see back for additional information