GAYLORD WELLNESS PROGRAM K-6

HEALTH DEPARTMENT of Northwest Michigan

Parent/Guardian/Adult Consent for Services

STUDENT INFORMATION

Name:_____ Preferred Name:_____ Date of Birth:_____ Age:_____

Gender: ☐ Male ☐ Female ☐ Other ☐ Decline Ethnicity : ☐ Non-Arabic/Non-Hispanic ☐ Hispanic

Race: ☐ White/Caucasian ☐ Black/African American ☐ Native American ☐ Asian ☐ Other ☐ Multiple ☐ Decline

Street Address:_____ Mailing Address:_____ City:_____Zip:_____

Student Phone Number:_____ Student Email:_____

Parent/Guardian Name:_____ Phone:_____ Legal Custody: ☐ Yes ☐ No

Relationship:_____ Email:_____

Parent/Guardian Name:_____ Phone:_____ Legal Custody: ☐ Yes ☐ No

Relationship:_____ Email:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

SERVICES AVAILABLE

NURSING: These services include a school nursing assessment and care for minor injury and illness, administering limited over-the-counter medication, coordinating care and chronic disease management with the school and primary care provider, providing basic laboratory services and tests, assessing immunizations, providing referrals to establish primary care and oral healthcare providers, assessing mental health and risk behaviors, and accessing nurse practitioners through telemedicine.

MENTAL HEALTH: These services include individual, family, and group counseling, crisis intervention, assessment of risk behaviors, and may also include student substance abuse services, health education, risk reduction counseling, communication with the patient's primary care provider, and Medicaid outreach and enrollment. Telehealth services may also be offered.

GAYLORD WELLNESS PROGRAM K-6 POLICY

Parents/Guardians must provide consent for their minor children for services at Gaylord Wellness. Minors without consent will only be seen one time with verbal parent/guardian permission. Exceptions to this policy, required by federal and Michigan laws*, include emergencies threatening life or limb, and substance abuse services. Minors 14 years and older can obtain mental health services up to 12 sessions or 4 months without parent/guardian consent. People who are 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 U.S. Armed Forces provide consent for services themselves.

Services NOT provided:

- **Immunizations.**
- **Prescribing or Dispensing Prescription Medications.**
- **Family Planning Medications & Devices.**
- **Abortion Counseling, Referrals or Services.**

CONSENT FOR SERVICES

By signing this consent form, I certify that I am the parent/legal guardian of the student named above and give consent for the following services: (check one)

☐ Mental health **AND** nursing services ☐ Mental health services **ONLY** ☐ Nursing services **ONLY**

I agree that I have reviewed, understand the Gaylord Wellness Program services I've stipulated above. This consent does not need to be renewed yearly, and I can withdraw my consent any time in writing. Otherwise, consent applies until my child is age 18. In addition, I acknowledge that:

- All medical records are protected by HIPAA and will only be released in accordance with the Gaylord Wellness Program policy, which is available for review.
- Services, including certain confidential services, operate in compliance with federal and Michigan laws.*
- I received a copy of the Health Department's Notice of Privacy Practices.
- Testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate consent if a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- Staff may access school records, such as PowerSchool, to coordinate appointments and services.

Signature of Parent/Guardian/Adult:_____**Date:**_____

STUDENT INSURANCE INFORMATION

☐ No insurance (uninsured)	**Card Number:**
☐ Medicaid/Medicaid HMO	**Policy Holder:**
☐ Blue Cross Blue Shield	**Group Number:**
☐ Blue Care Network	**Policy Holder Birth Date:**
☐ Priority Health	**Relationship to Student:**
☐ TriCare	
Other:	

CONTACT ME FOR INFORMATION REGARDING

- ☐ Health insurance options
- ☐ Finding a Healthcare Provider
- ☐ Finding a Dentist
- ☐ Paying for medical bills
- ☐ Emotional wellbeing of child or adult in my home
- ☐ Paying for transportation to Healthcare Provider
- ☐ Help paying for heat/water/utility bills
- ☐ Shelter ☐ Food ☐ Clothing

STUDENT HEALTH INFORMATION

Allergy (Medicine, Food, Environment)			**Reaction/Severity**		
Medication/Prescription/Vitamins	**Dose**	**Frequency**	**Route**	**Who prescribed medication?**	**Reason**

Check if your student has had any of the following:

☐ ADD/ADHD	☐ Anxiety	☐ Unexplained Tiredness	☐ Shortness of Breath/Asthma
☐ Autoimmune disorders	☐ Depression	☐ Blood disorder/cancer	☐ Head, Eyes, Ears, Throat Problems
☐ Anemia	☐ Sleep Problems	☐ Unexplained Weight Gain/Loss	☐ Blood Transfusions
☐ Birth Defects	☐ Abnormal Mood Swings	☐ Eating Concerns	☐ Anaphylactic Episodes
☐ Diabetes	☐ Seizures	☐ Stomach or Bowel Problems	☐ Joint or Muscle Pain or Stiffness
☐ Developmental Disorders	☐ Chest Pain	☐ Head Injury	☐ Physical/sexual/other trauma
☐ Developmental Disabilities	☐ Cognitive Impairment	☐ Headaches	☐ Other _____

Birth: ☐ C-section ☐ Vaginal ☐ Premature Birth: # weeks: ____ Prenatal/Delivery Complications: _____

Any trouble meeting developmental milestones? (i.e. speech, gross/fine motor): _____

Please describe anything checked above: _____

Serious injuries or illness (describe): _____

Surgeries (reason/date): _____

Hospitalizations (reason/date): _____

Student's Doctor: _____ Phone: _____

Student's Dentist: _____ Phone: _____

FAMILY MEDICIAL HISTORY

Please check the if any of the student's blood relatives (mother, father, sibling, grandparent) have any of the following conditions:

☐ HIV/AIDS	☐ Bleeding Disorders	☐ High Blood Pressure	☐ Sickle Cell
☐ Alcohol/Drug Addiction	☐ Cancer	☐ High Cholesterol	☐ Thyroid Disorder
☐ Alzheimer's	☐ COPD/Emphysema/Bronchitis	☐ Kidney Disease	☐ Tuberculosis/TB
☐ Arthritis	☐ Diabetes	☐ Liver Disease/Hepatitis	☐ Other: _____
☐ Asthma	☐ Epilepsy/Seizures	☐ Mental Illness	☐ Other: _____
☐ Blood Disorder	☐ Heart Attack/Stroke	☐ Osteoporosis	☐ Other: _____

*Laws include Child Protection Law Act 238 of 1975, Civil Rights Act of 1991, Health Insurance Portability & Accessibility Act of 1996, Michigan's Mental Health Code which includes minor consent, Public Health Code, Communicable Disease Rules, & Medical Records Access Act.