Student based healthcare center located inside Loy Norrix High School. Serving youth from 5 to 21 years

Knights Health Center

606 E. Kilgore Rd, Kalamazoo, MI 49001
269-337-0200 HealthyKnights@kalcounty.com

Kalamazoo Public Schools
Every child. Every opportunity. Every time.

PARENT/GUARDIAN/CLIENT CONSENT FORM

(Please read and complete front and back)

Student Name: _____ Preferred Name: _____

Date of Birth: _____Age: _____ Sex Assigned at Birth: _____

Gender Identity: _____ Grade: _____ School: _____

Student Cell: _____ Can we text you? (circle one) YES NO

SERVICES THAT MAY BE PROVIDED AT THE KNIGHTS HEALTH CENTER

- Comprehensive physical exams (i.e., well-child exams) for school, sports, and camps (may include vision and hearing tests, basic lab tests, etc.)
- Primary health care services
- Sick care/ minor illness
- Treatment for acute & chronic illness & injuries
- Over-the-counter medications
- Immunizations
- Education/ support programs for smoking cessation, nutrition/ fitness, parenting, etc.
- Referrals for specialty services
- *Substance abuse education, counseling, and referrals
- *Mental health and psycho-social assessment, prevention, education, support groups, individual or group counseling/therapy , and referrals
- *Sexually Transmitted Infection (STI) & HIV testing, treatment, and counseling
- *Pregnancy prevention counseling, testing, and referrals

(*) Current Michigan Law allows for confidential services to minors in these areas. They do not require parental consent.

SERVICES ***NOT*** PROVIDED:

NO dispensing or prescribing birth control pills or devices
NO abortion counseling, referrals, or services

- I give my consent for the above-named student to receive all services as indicated in this.
  - ☐ _____If you do ***NOT*** want your child to be given any over-the-counter medications (i.e., Tylenol), check the box and initial.
  - ☐ _____If you do ***NOT*** want your child to receive immunizations, check the box and initial.

Revised 02/11/2025

- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. Or by signing this consent form, I verify that I am a student and that I am 18 years old or older.
- I understand that it is not necessary to renew my consent yearly, but it is necessary to have updated address, phone, insurance, and my child's current health information.
- I further authorize the Knights Health Center (KHC) to release information regarding treatment to the following KHC Staff and its subcontractors (health center manager, nurse practitioner; medical assistant; clinical social worker and supervising licensed social worker), and third-party payers when needed for payment of services.
- I understand that school staff (i.e.: school counselors, teachers, & administrators) and/or community service providers (i.e.: Communities in Schools) may be contacted to coordinate services (i.e., to miss part of a class for an appointment, for acknowledgment of a referral to the KHC, and follow-up that contact with a student has been attempted.).
- I understand that I may withdraw my consent for services at any time upon prior written notice.
- I authorize both the KHC and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care.
- I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics and will have the opportunity to give feedback on services and programs through surveys or focus groups.
- I understand that my child may be administered a behavioral risk assessment (RAAPS) during their appointment at our clinic.
- I understand that testing for bloodborne diseases, including HIV/ AIDS, may be performed upon a patient without separate written consent if a healthcare professional received a cut or was exposed to my child's blood or body fluids.
- The Knights Health Center staff will call 911 first and then parents/guardian in an emergency. I do not need to give permission or consent for emergency transportation.
- I understand that telehealth or virtual health care from the Knights Health Center may be offered / provided.
- I understand that my insurance will be billed directly for services, and I will not be billed for any co-pays.
- I understand that there may be a small, nominal cost for sports physicals that may be waived if I am unable to pay for this service.
- I understand that I will not be denied services if I don't have insurance or if I am unable to pay for services. Services will be provided regardless of the ability to pay.
- I understand that my privacy and health information will be handled in a confidential manner as required by the Health Information and Privacy Act (HIPAA) as set forth by Kalamazoo County of Health & Community Services Department Notice of Privacy Practices.

SIGNATURE OF PARENT/GUARDIAN/CLIENT: _____ **DATE**: _____

RELATIONSHIP TO STUDENT: _____

EMAIL ADDRESS: _____

PHONE NUMBER:_____

RETURN TO*: The Knights Health Center or the LNHS Main Office*

KNIGHTS HEALTH CENTER

Registration/ Billing Information

Demographic Information

Student Name (last, first, middle initial)	**Birthdate (mm/dd/yyyy)**	**Race (circle all that apply)** Am. Indian/ Alaskan Asian /Pacific Islander Black Multi-Racial White Unknown Ethnicity Arab Hispanic Non-Arabic/ Hispanic Decline to answer

Address (include Apt.#)	**City**	**Zip Code**	**Home Phone #**	**Parent Cell #**

Parent/ Guardian	**Relationship to Student**	**Parent Work Phone #**
Emergency Contact	**Relationship**	**Phone #**

Does student live with parents _____Yes _____No If not, where? _____

***INSURANCE (**see below)**

_____None/Uninsured (please contact me to help obtain MI Child/ Healthy Kids health insurance for my child) _____Yes _____No

_____ Medicaid/ MI Child _____ Blue Cross Blue Shield _____Priority _____ Other: _____

_____ MI Health (Student's Card Number: _____)

ID #	**Policy #**	**Group #**	**Coverage Code**
Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**

Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** ____Yes _____ No

SECONDARY INSURANCE (If applicable)

_____Medicaid/ MI Child _____Blue Cross/ Blue Shield _____ Priority _____ Other: _____

ID #	**Policy #**	**Group #**	**Coverage Code**
Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**

Member Employer	**Employer Address**	**Does your insurance pay for immunizations?** _____Yes _____ No

***Please note: Services *<u>are not</u>* denied based on inability to pay.**

****Please copy front and back of insurance car(s) and return it with this form.**

Parent/ Guardian/ Client Initials: _____

STUDENT NAME:	DATE OF BIRTH:	TODAY'S DATE:
PEDIATRICIAN/FAMILY PROVIDER NAME:	DATE OF LAST PHYSICAL EXAM: MONTH: YEAR:	DATE OF LAST DENTAL EXAM: MONTH: YEAR:
MEDICATION ALLERGIES/REACTION: YES NO	OVERNIGHT HOSPITALIZATIONS: YES NO	MEDICATIONS (prescription, over the counter, and/or vitamins): NAMES AND DOSAGES: _____ _____ _____ _____ _____ PREFERRED PHARMACY:
FOOD ALLERGIES: YES NO	SURGERIES: YES NO	
OTHER ALLERGIES (i.e. dust, pollen, latex, etc.) : YES NONE	BROKEN BONES/FRACTURES: YES NONE	
BEE STING ALLERGY? YES NONE		

STUDENT HEALTH CONDITIONS	(CIRCLE YES OR NO, AND COMMENT IF NEEDED)	
ADD/ADHD: YES NO	**Asthma:** YES NO	**Diabetes** (high blood sugar): YES NO
Learning Difficulty/Special Needs: YES NO	**Other Difficulty Breathing:** YES NO	**Cancer:** YES NO
Headaches/Migraines: YES NO	**Heart Problem:** YES NO	**Stomach/Intestine Problems:** YES NO
Seizure: YES NO	**Murmur:** YES NO	**Kidney/Urinary Problems:** YES NO
Eczema/Rashes: YES NO	**Hypertension** (high blood pressure): YES NO	**Depression:** YES NO
Anemia (low iron/ blood count): YES NO	**Fainting** (passing out/syncope): YES NO	**Anxiety:** YES NO
Hearing Impairment: YES NO	**Vision Impairment:** YES NO	

Additional Information:

_____

_____

STUDENT NAME:	DATE OF BIRTH:

FAMILY HISTORY		
PLEASE CHECK ALL THAT APPLY		NOTE WHICH RELATIVE THAT HAS/HAD THIS CONDITION
	ASTHMA/ EMPHYSEMA/ COPD	
	HYPERTENSION (high blood pressure)	
	HIGH CHOLESTEROL	
	CANCER (please specify type)	
	DIABETES (high blood sugar)	
	STROKE	
	SEIZURES	
	KIDNEY PROBLEMS	
	HEART PROBLEMS	
	MENTAL HEALTH CONCERNS (please specify)	
	DEATH UNDER AGE 50 CAUSE:	

Additional Information:

_____

_____

ADDITIONAL QUESTIONS	
DOES STUDENT NEED A LANGUAGE INTERPRETER? YES NO WHICH LANGUAGE?	DOES STUDENT NEED A SIGN LANGUAGE INTERPRETER OR HEARING ASSISTANCE? YES NO
DOES THE STUDENT NEED VISION ASSISTANCE? YES NO	WOULD YOU LIKE TO USE THE PATIENT PORTAL? YES NO EMAIL ADDRESS:
WOULD YOU LIKE TO BE CALLED EVERY TIME BEFORE OVER-THE-COUNTER MEDICATION AND/OR PRESCRIPTION MEDICATION IS ADMINISTERED? YES NO	WOULD YOU LIKE A CALL AFTER EVERY TIME YOUR STUDENT VISITS THE KNIGHTS HEALTH CENTER? YES NO
WOULD YOU LIKE TO SPEAK WITH THE HEALTH CARE PROVIDER REGARDING YOUR STUDENT? YES NO	WOULD YOU LIKE TO SPEAK WITH THE CLINICAL SOCIAL WORKER REGARDING YOUR STUDENT? YES NO

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

OFFICE ONLY: REVIEWED BY: _____ DATE: _____

Approved as to form for **KALAMAZOO COUNTY CORPORATION COUNSEL**
By: Lewis L. Smith, Corporation Counsel
Date: February 11, 2025