Sault Health Adolescent Care Center

Chippewa County Health Department

904 Marquette, Room 622
Sault Ste. Marie, MI 49783
Phone: (906)632-5690 Fax: (906)635-1325

PARENT/GUARDIAN CONSENT FORM

Please read and complete. Consent contains 4 pages

Consent is needed for each student if: one has not previously been completed OR any changes have occurred since the last form was completed.

Student Name (Last Name, First Name, Middle Initial) *	Birth Date *	Age	Sex * Male ❒ Female ❒	Grade	School

Address *	City *	Zip Code *	Student Telephone #	Today's Date

Race / Ethnicity (Optional)

❒ Black or African American ❒ White ❒ Hispanic/Latino ❒ American Indian/Alaskan Native ❒ Arab ❒ Asian ❒ Native Hawaiian/Pacific Islander

Mother/Guardian: Last Name	First Name	M.I.	Relationship to Student

Daytime Telephone #	Work Telephone #	Cellular / Pager #	Parent E-Mail Address

Father/Guardian: Last Name	First Name	M.I.	Relationship to Student

Daytime Telephone #	Work Telephone #	Cellular / Pager #	Parent E-Mail Address

Name Of Emergency Contact	Relationship	Telephone #

Name of Student's Physician/Clinic	Telephone #

Name of Student's Dentist	Telephone #

Would you like your child to receive Dental Care at the SHACC? ❒ Yes ❒ No

Name of Student's Employer	Your estimate of student's annual income

Medical Insurance *

❒Medicaid ❒ Blue Cross/Blue Shield ❒ NGS Insurance ❒ MI Child ❒ TRICARE ❒ Other: _____ ❒ No insurance

I.D./Contract # *	Policy/Group # *	Student Relationship to Policy Holder *

Policy Holder Name (Last Name, First Name, Middle Initial) *	Policy Holder Date of Birth *	**Please provide a photocopy of both sides of your insurance card.**

Address *	City *	State *	Zip Code *

Dental Insurance *

❒Medicaid ❒ Blue Cross/Blue Shield ❒ NGS Insurance ❒ MI Child ❒ TRICARE ❒ Other: _____ ❒ No insurance

I.D./Contract # *	Policy/Group # *	Student Relationship to Policy Holder *

Policy Holder Name (Last Name, First Name, Middle Initial) *	Policy Holder Date of Birth *	**Please provide a photocopy of both sides of your insurance card.**

Address *	City *	State *	Zip Code *

I understand that treatment for oral health, general medical and behavioral health services may be obtained at my primary provider's office and that obtaining duplicate services may affect my benefits received from private, state or federal insurances or third-party provider of dental benefits. ***(Turn over and complete)***

I consent to all of the following:

- The Sault Area Public Schools may release information to the Sault Health Adolescent Care Center for the purpose of receiving treatment. This includes school photos for the purpose of identification.
- The above-named student may receive all services listed below at the Sault Health Adolescent Care Center (SHACC). If I am requesting any changes to this consent, I will submit the changes to the SHACC in writing separately.
- The completion of a risk assessment by the above-named student.
- The Sault Health Adolescent Care Center may release information regarding treatment to third party payers or others for the purpose of receiving payment for services. If required by law, separate release forms will be used at time of service.
- Both the Sault Health Adolescent Care Center and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- The Sault Health Adolescent Care Center may obtain a copy of the above-named student's/patient's immunization record from the student's/patient's school office, and/or their primary care provider's office.
- This consent form will remain active and on file at the Sault Health Adolescent Care Center while my student is enrolled in the Sault Area High School, Malcolm High School, Sault Middle School or Sault Area Career Center unless rescinded by me in writing.

Services provided at the Sault Health Adolescent Care Center

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
➢ Physical exams for school, sports, and camp ➢ Treatment for acute & chronic illness & injuries ➢ Vision/hearing screenings and follow-up ➢ Oral/dental screening and follow-up/preventive care ➢ Administration of anesthetic/nitrous oxide ➢ Immunizations ➢ Basic laboratory services & tests ➢ Administration of medication ➢ Individual, group, family, and community education ➢ Referrals for specialty services	➢ Gynecological services ➢ Pregnancy testing and referrals ➢ Sexually transmitted disease screenings, treatment, and counseling ➢ HIV screening and referrals ➢ Physical/sexual abuse counseling and referrals ➢ Crisis Intervention ➢ Substance abuse education, counseling and referrals ➢ Mental health assessment, counseling, and referrals

PARENTAL CONSENT IS NOT NEEDED FOR CRISIS INTERVENTION AND EMERGENCY CARE

LIMITATION OF SERVICES

◆***NO*** birth control pills or devices are dispensed or prescribed ◆***NO*** abortion counseling, referrals or services are provided

By signing this consent form, I certify that I am the parent/legal guardian of the student, or student at least 18yrs old, named above and is registered with the school as such.

SIGNATURE OF PARENT/GUARDIAN: _____DATE: _____
(or student at least 18yrs old)

We serve students enrolled in Sault Area High School, Middle School and Malcolm School, without regard to race, religion, color, national origin, creed, handicap, sex, sexual orientation, or sexual preference. Services are also provided to infants and pre-school children of students.

STUDENT HISTORY

STUDENT MEDICAL HISTORY: Please check Yes or No

Bee sting allergies	❒ Yes ❒ No	Learning Disability	❒ Yes ❒ No
Medication allergies (type:)	❒ Yes ❒ No	Seizure (epilepsy)	❒ Yes ❒ No
Food allergies (type:)	❒ Yes ❒ No	Anemia (low iron/blood count)	❒ Yes ❒ No
Allergies, i.e. hay fever, dust, pollen	❒ Yes ❒ No	Stomach problems	❒ Yes ❒ No
Asthma	❒ Yes ❒ No	Heart problems	❒ Yes ❒ No
Diabetes (high blood sugar)	❒ Yes ❒ No	Bladder problems	❒ Yes ❒ No
Eczema/Rashes	❒ Yes ❒ No	Cancer	❒ Yes ❒ No
Headaches/Migraines	❒ Yes ❒ No	**Taking daily medication(s)** *	❒ Yes ❒ No
ADD / ADHD	❒ Yes ❒ No	*Name of medication(s)	
Hypertension (high blood pressure)	❒ Yes ❒ No	*Condition for medication(s)	
Sickle cell (trait or disease)	❒ Yes ❒ No	Surgeries (type:)	❒ Yes ❒ No
Fainting	❒ Yes ❒ No	Overnight Hospitalizations (why:)	❒ Yes ❒ No
Pneumonia	❒ Yes ❒ No	Pounding of Heart	❒ Yes ❒ No
Kidney Disease	❒ Yes ❒ No	Shortness of Breath	❒ Yes ❒ No
Painful Joints	❒ Yes ❒ No	Frequent Urination	❒ Yes ❒ No
Backaches	❒ Yes ❒ No	Nosebleeds	❒ Yes ❒ No
Thyroid Disease	❒ Yes ❒ No	Frequent Sore Throats	❒ Yes ❒ No
Anxiety	❒ Yes ❒ No	Hearing Loss	❒ Yes ❒ No
Depression	❒ Yes ❒ No	Vision Problems	❒ Yes ❒ No
Developmental Disability	❒ Yes ❒ No	Other Health Problems:	

If you answered yes to any question or have a condition not mentioned, please explain:

_____

_____

STUDENT DENTAL HISTORY:

Date of last dental visit:		Date of last dental x-rays:	
Reason for last visit:			
Concerns about previous dental care or this visit:			
Do your gums bleed?	❒ Yes ❒ No	Are your teeth loose?	❒ Yes ❒ No
Have you ever been told you have gum disease?	❒ Yes ❒ No	Have you ever been told you have bad breath?	❒ Yes ❒ No
Are your teeth sensitive to:	❒ Sweets ❒ Cold ❒ Heat ❒ Pressure	Have you ever had any pain in your jaw joints? (clicking, popping)?	❒ Yes ❒ No

FAMILY MEDICAL HISTORY: Please check below if any of your child's relatives (mother, father, sister, brother, aunt, uncle, grandparents, etc.) have had any of the following illnesses and note what relative had them.

❒ Heart Problems	❒ Cancer
❒ Cholesterol	❒ Diabetes (high blood sugar)
❒ High Blood Pressure	❒ Stroke
❒ Asthma/Emphysema/Bronchitis	❒ Seizures
❒ Death under age 50 (cause:)	❒ Kidney or Thyroid Disease
❒ Sickle Cell Anemia/Blood problems	❒ Other

(Turn over and complete)

CONCUSSION MANAGEMENT PROGRAM CONSENT

By signing below, I agree to all of the following: Consent for my student athlete to participate in the Concussion Management Program, Consent for the SHACC to hold all pre-season test results and any post-injury results, Consent for the SHACC Nurse Practitioner to provide information to my student athlete's primary care physician in the event of an injury, I understand that in the event of an injury, information regarding treatment may be released to third party payers or others for the purpose of receiving payment for services. If required by law, separate release forms will be used at the time of service.

Parent/Guardian: _____ Date: _____ Primary Care Physician: _____

MICHIGAN CHILDHOOD IMMUNIZATION REGISTRY AND VACCINE ADMINISTRATION CONSENT

I understand my child's immunization (shot) records from school district files and the Michigan Care Improvement Registry will be reviewed to ensure records are up to date. If it is determined that my child needs a shot (vaccine), I give my permission for it to be given at the SHACC. If I do not want shots (vaccines) given to my child, I will check the NO. I do not agree box below.

☐ Yes, I agree to immunization updates ☐ No. I do not agree

Parent/Guardian Signature _____Date:_____

With this exception to these immunizations: _____

Medication Consent

I understand that medications are available in the SHACC to relieve minor discomforts. Lists of these medications are available for you to obtain by asking the office staff. If my child has complaints, and the Nurse Practitioner or Dentist advise, I give my permission to administer the appropriate medication.

☐ Yes, I agree ☐ No. I do not agree Parent/Guardian Signature _____Date:_____

Additional Notes: _____

We will contact you if minor discomforts occur frequently and/or are a concern to our medical staff. This permission will remain in effect unless otherwise revoked in writing.

Photo Consent

I understand that on occasion the SHACC uses photographs of school and SHACC activities in materials that are circulated to the public. These photographs may include students. I give permission to the SHACC to include photographs of my child in these materials.

☐ Yes, I agree ☐ No. I do not agree Parent/Guardian Signature _____Date:_____

Consent and Statement of Understanding Regarding Telehealth (Online Therapy) Sessions

I understand there are some strengths and some limitations with participating in telehealth. I assume the risk of poor internet connection with my devices or lack of privacy in my home. I am aware and agree that telehealth is not an appropriate option for emergency services. If I experience suicidal/homicidal thoughts, or if some other crisis occurs, I am aware and agree that I will be referred for in-person crisis services to my local emergency room or community mental health emergency services. I authorize my therapist to contact my parent or emergency contact if they believe I may be in any danger during the therapy session.

I understand that there is a possibility that our technology may fail during a telehealth session, and that there may be an interruption. Such an interruption may necessitate a need to continue by phone, or the session may need to be rescheduled.

I understand that my provider or I can discontinue the telehealth consult/visit if it is felt that the telehealth service is not adequate for the situation.

Telehealth services will be provided through Doxy.me HIPAA compliant telemedicine.

I understand to maintain my confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

I hereby authorize Sault Health Adolescent Care Center to use telehealth technology for my therapy sessions. By signing below, I acknowledge that I have read, understood, and have been able to ask any questions about this service, and that these questions have been answered to my satisfaction.

☐ Yes, I agree to Telehealth services ☐ No. I do not agree

Student Signature _____Date:_____

Parent/Guardian Signature _____Date:_____