BlueJay Wellness Center
238 S. Chippewa Street
Shepherd, MI 48883

PARENT/ GUARDIAN/ CLIENT CONSENT FORM

(Please read and complete front and back)

Student Name: _____ **Date of Birth:** _____ **Age:** _____

Gender: _____ **Grade:** _____ **School:** _____

SERVICES THAT MAY BE PROVIDED AT THE WELLNESS CENTER

- Physical Exams for School, Sports, and Camps
- Primary HealthCare Services
- Sick Care/ Minor Illness
- Treatment for Acute &Chronic Illness & Injuries
- Over-the-Counter Medications
- Immunizations
- Health Education / Risk Reduction Counseling/ Support Programs
- Referrals for Services Not Provided at the Wellness Center
- *Mental Health Services, Counseling, and Referrals
- *Physical/ Sexual Abuse Counseling and Referrals
- *Substance Abuse Education, Counseling, and Referrals
- *Pregnancy Testing, Counseling, and Referrals
- *Sexually Transmitted Infection Testing, Treatment, and Referrals
- *HIV Testing, Counseling, and Referrals

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

SERVICES NOT PROVIDED:

NO distributing or prescribing of family planning drugs 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 document.

☐ If you do **NOT** want your child to be given any over-the-counter medications (i.e. Tylenol), check this box.

☐ If you do **NOT** want your child to receive immunizations, check this box. Immunizations will not be given without specific written or verbal consent of the parent/guardian. Visit Michigan VIS for the most current Vaccine Information Statements (VIS).

- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above.
- 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 Wellness Center (WC) to release information regarding treatment to the following: WC Staff and its' subcontractors, school staff (for the purposes of coordination of services, student success, and safety in accordance with HIPAA), and third-party payers when needed for payment of services.
- I understand I may withdraw my consent for services at any time upon prior written notice.
- I authorize both the WC 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 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 in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I understand that services are provided with charges based on the client's income, and I understand that no one will be denied services regardless of ability to pay. Services are offered without regard to sex, race, religion, or sexual preference.
- 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 CMDHD (see attached notice).
- I understand that telehealth may be an appropriate service. All existing laws that apply to face-to-face services also apply to telehealth.
- I understand reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth.
- I understand telehealth can include consultation, treatment, transfer of medical/mental health data, emails, telephone conversations and/or education using interactive audio, video, or data communications.
- It is not within the counselor's scope of practice to complete custody evaluations. Therefore, counselors will not be testifying in custody cases.

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

Office Use Only:
PH#: _____

ADOLESCENT WELLNESS CENTER
Registration/ Billing Information
Demographic Information

Student Name	**Birthdate**	**Race** ☐ Caucasian/White ☐Black/African American ☐Asian ☐Native Hawaiian/Pac Islander ☐Multi-Racial **Ethnicity** ☐Arab ☐Hispanic ☐Non-Arabic/ Hispanic

Address	**City**	**Zip Code**	**Student Cell #**

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

Emergency Contact	**Relationship to Student**	**Phone #**

Does Student live with parents? _____ Yes _____ No If not, where? _____

INSURANCE *Please, fill out completely. (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: _____)

Policy #	**Group #**

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: _____

Policy #	**Group #**

Member Name	**Birth Date**	**Social Security #**	**Relationship to Student**

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

*** PLEASE NOTE: SERVICES ARE NOT DENIED BASED ON INABILITY TO PAY.**

**** PLEASE COPY FRONT AND BACK OF INSURANCE CARD(S) AND RETURN IT WITH THIS FORM.**

Parent/Guardian/Self Initials _____

CLIENT MEDICAL HISTORY

NAME OF PRIMARY CARE PROVIDER:	DATE OF LAST PHYSICAL EXAM: MONTH: YEAR:	DATE OF LAST DENTAL EXAM: MONTH: YEAR:
MEDICATION ALLERGIES: ☐YES ☐NO TYPE:	OVERNIGHT HOSPITALIZATIONS: ☐YES ☐NO REASON:	MEDICATIONS (prescription, over the counter, and/or vitamins): ☐YES ☐NO NAMES AND DOSAGES: _____ _____ _____ _____
FOOD ALLERGIES: ☐YES ☐NO TYPE:	SURGERIES: ☐YES ☐NO TYPE:	
ALLERGIES (i.e. dust, pollen, etc.): ☐YES ☐NO TYPE:	BROKEN BONES: ☐YES ☐NO DESCRIBE:	
BEE STING ALLERGY? ☐YES ☐NO	PREFERRED PHARMACY:	

ADD/ADHD ☐YES ☐NO	ASTHMA ☐YES ☐NO	DIABETES (high blood sugar) ☐YES ☐NO
LD/ SPECIAL NEEDS ☐YES ☐NO IEP ☐YES ☐NO 504 ☐YES ☐NO	HEADACHES/MIGRAINES ☐YES ☐NO	CANCER ☐YES ☐NO
	HEART PROBLEM ☐YES ☐NO	STOMACH 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 ☐YES ☐NO	ANXIETY ☐YES ☐NO
OTHER (please specify):	DOES YOUR CHILD SEE A MENTAL HEALTH THERAPIST? ☐YES ☐NO	

Additional Information:

_____

_____

FAMILY MEDICAL HISTORY

☐YES ☐NO	ASTHMA/ EMPHYSEMA/ COPD	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HYPERTENSION (high blood pressure)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HIGH CHOLESTEROL	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	CANCER (please specify type)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	DIABETES (high blood sugar)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	STROKE	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	SEIZURES	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	KIDNEY PROBLEMS	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	HEART PROBLEMS	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	MENTAL HEALTH CONCERNS (please specify)	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	DEATH UNDER AGE 50 CAUSE:	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:
☐YES ☐NO	OTHER	☐MOM ☐DAD ☐SIBLING ☐GRANDPARENT ☐OTHER:

Additional Information:

_____

_____

_____

_____

RESOURCE ASSISTANCE	
WOULD YOU LIKE INFORMATION FROM OUR STAFF REGARDING THE FOLLOWING? -OPTIONS FOR HEALTH INSURANCE? ☐YES ☐NO -FINDING A HEALTH CARE PROVIDER? ☐YES ☐NO (doctor or nurse practitioner) -FINDING A DENTIST? ☐YES ☐NO	WOULD YOU LIKE MORE INFORMATION REGARDING MENTAL HEALTH SERVICES FOR YOUR CHILD? ☐YES ☐NO ARE YOU CONCERNED ABOUT YOUR INCOME MEETING THE BASIC NEEDS OF YOUR FAMILY? ☐YES ☐NO Please mark concerns: ☐FOOD ☐CLOTHING ☐HOUSING ☐TRANSPORTATION TO MEDICAL OR SCHOOL APPTS ☐HEAT/WATER BILLS **IF YOU ANSWERED YES TO ANY OF THE ABOVE, A MEMBER OF OUR STAFF MAY CONTACT YOU.**

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

For office use:

Reviewed with client: _____ DATE: _____

The Adolescent Wellness Center is operated by Central Michigan District Health Department with major funding from the Michigan Departments of Health and Education.

For more information about the CAHC and your rights associated with the transmission of your information through this and other health information exchanges, please contact Us @ BJWC@cmdhd.org

Email completed form to: BJWC@CMDHD.ORG or
RETURN Printed copy to: *The Wellness Center*

CENTRAL MICHIGAN DISTRICT HEALTH DEPARTMENT CLINIC SIGNATURE FORM

Patient Name: _____ **Birthdate:** _____

I give my permission to Central Michigan District Health Department to release my medical information to my medical insurance provider as required for billing purposes.

If your service(s) are not a covered benefit under your insurance plan, and you have not met your deductible and/or co-pays or are out of network, you will not be billed for the cost of service(s) and/ or administration fees as directed by the state of Michigan.

I acknowledge receiving a current Notice of Privacy Practices on ____/____/____ from Central Michigan District Health Department.

IMMUNIZATION CLIENTS:

I have been given a copy and have read, or have had explained to me, the information contained on the appropriate Vaccine Information Statement (VIS) about the disease(s) and the vaccine(s) which are to be administered today. If your service(s) are not a covered benefit and you are eligible for the VFC program (Vaccines for Children), as a CAHC client, you will not be billed the administrative free.

I understand that the notice contains my rights and the Health Department's responsibilities regarding my protected health information. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the specific service(s) and I ask that the service(s) I have requested be given to me, or the person named above for whom I am authorizing to make this request, and I ask that the administration of the service(s) be recorded.

Communication Choices:

Appointment Reminders are considered part of treatment of an individual and, therefore authorization. However, I will allow contact from this office to confirm my appointments, treatment and billing information (for programs in which they are available) by the following methods:

- ☐ Home phone
- ☐ Cellphone
- ☐ Voicemail
- ☐ Work Phone
- ☐ Texting
- ☐ US Postal Service
- ☐ Email

☐ I wish for no communication or contact other than when I am in person at the clinic.

I am aware and agree that:

- Information sent by Wellness Center or Central Michigan District Health Department can be viewed by people other than me on my personal device if I do not keep it secure. I accept these risks when I choose to receive electronic notifications.
- I am responsible to keep my information always updated with Wellness Center to keep from accidental information sharing.
- I can end this acknowledgement and change my mind about these choices in writing to the Wellness Center at any time.

Please list any other parties who can have access to your health information:

By listing these persons below, I give the CMDHD the authorization to disclose my protected personal health information about my appointments, medical care, records or results with the following individual listed below:

- ☐ Spouse/Partner_____
- ☐ Child(ren)_____
- ☐ Other_____

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

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RETURN Printed copy to: *The Wellness Center*