A close up of a logo

Description automatically generatedText

Description automatically generated

**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**

**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.

**Services NOT provided:**

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

**CHAR-EM WELLNESS PROGRAM POLICY**

Parents/Guardians must provide consent for their minor children for services at the Char-Em Wellness Program. Minors without consent will only be seen one time with verbal parent/guardian permission. Exceptions to this policy, required by federal and Michigan laws\*, are emergencies threatening life or limb, substance abuse services, family planning counseling, HIV counseling and testing, sexually transmitted infection screening and treatment. 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.

**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 mental health services.

I agree that I have reviewed, understand the Char-Em Wellness Program services. 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 Char-Em 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 CONTACT ME FOR INFORMATION REGARDING**

**STUDENT HEALTH 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: |  |

|  |
| --- |
| ⬜ 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 |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **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.