Benzie-Leelanau
District Health Department
Caring for our Communities

School Wellness Program (SWP)

Student Health Information and Consent

Students can see a Registered Nurse and/or *Licensed Therapist at school.

8.1.23

Name (Last Name, First Name, M.I.)	Birth Date	Age	Grade	School
Address	City	Zip Code	Student Telephone	Today's Date

Race: __American Indian __Black/African American __White __Asian __Other Gender: __Male __Female
Ethnicity: __Hispanic/Latino __ Not Hispanic/Latino __ Other: ________________

Parent/Guardian Last Name	First Name	M.I.	Relationship to Student
Daytime Telephone #	Work Telephone #	Cellular #	Parent Email Address
Name of Emergency Contact	Relationship	Telephone #	
Name of Insurance		Preferred Hospital	
I.D./Contract #	Policy/Group #	Student Relationship to Policy Holder	
Policy Holder Name (Last Name, First Name, M.I.)		Policy Holder Date of Birth	
Address	City	State	Zip Code

I consent to all the following:

- The above named may receive services at the SWP by the Registered Nurse and/or *Licensed Mental Health Provider (see page 2).
- This consent remains active until rescinded, or the student reaches age 18.
- I understand that any changes to my information, or to rescind this consent, must be submitted in writing.
- I understand that students without signed parent/guardian consent won't be seen, except for an emergency or student's first visit to the SWP Nurse, when staff will call the parent/guardian before providing any services, for a one-time-only verbal consent.
- **I understand that the SWP and my child's primary provider may exchange health information for continuity of care.**
- I authorize the SWP to disclose protected health information from a visit for continuation of treatment, and internal peer review audit.
- I authorize the SWP to release information regarding treatment and care to the following: SWP staff, its subcontractors, and health care providers when needed to coordinate care; and relevant school staff, on a need-to-know basis, when needed to coordinate services for the health and safety needs for the student--including communicable disease response and insurance companies when needed for payment of services.
- I understand that testing for blood borne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent if a healthcare professional receives a cut or exposure to blood or body fluids.
- I have been given or have had the opportunity to review the BLDHD Privacy Notice (https://bldhd.org/privacy/). **I understand that services can be refused at any time.**
- I understand that SWP staff may access school records for the purpose of coordinating services and for overall program evaluation.
- I understand that a confidential risk assessment survey will be given to all students and/or parents.
- **I understand that State law allows certain confidential services for students that meet age criteria (see page 2)**
- I understand that currently there is no personal out-of-pocket cost for limited clinical or mental health services.
- **I understand that I am under no obligation to have my child use the SWP services.**

Parental consent and release of information is NOT needed for crisis intervention and emergency care.

LIMITATION OF SERVICES: Services not allowable under Michigan law or SWP program requirements include abortion counseling and referral; or prescribing and dispensing of family planning medications and devices.

OVER (COMPLETE BOTH PAGES OF THIS FORM)

The School Wellness Program is operated by the Benzie-Leelanau District Health Department, with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.

Student Name ____ **Birth Date** ___/___/_____

Last First

Student Health History

Does student have a doctor that they see regularly? ☐ Yes ☐ No

Doctor's Name & Phone ______________________________ **Date of last physical** ____________________

Does student have a dentist that they see regularly? ☐ Yes ☐ No

Dentist's Name & Phone ______________________________ **Date of last exam**____________________

1. Would you like information from our staff regarding:	
Options for health insurance**?	❒ Yes ❒ No
Finding a health care provider (doctor or nurse practitioner)?	❒ Yes ❒ No
Finding a dentist?	❒ Yes ❒ No
2. Do you have concerns about the emotional well-being of yourself/your child?	❒ Yes ❒ No
3. Are you concerned about your income meeting the basic needs of your family?	❒ Yes ❒ No
Please mark your concerns: ☐ Food ☐ Clothing ☐ Housing ☐ Paying for bills for heat and water ☐ Transportation to medical or appointments ☐ Other____________________	
If you answered YES to any of the above, a member of our staff will contact you	

****Free or low-cost health coverage for children under the age of 19, or pregnant women of any age, call the MI Child and Healthy Kids hotline at 1.888.988.6300 or for direct assistance, call, *Community Connections* serving Benzie and Leelanau Counties,** 1-833-674-2159, https://www.bldhd.org/community-connections

Please check YES or NO:

Bee sting allergies	☐ yes	☐ no	Seizures (epilepsy)	☐ yes	☐ no	Psychological disorder	☐ yes	☐ no
Anemia	☐ yes	☐ no	Stomach problems	☐ yes	☐ no	Thyroid disease	☐ yes	☐ no
Seasonal allergies	☐ yes	☐ no	Heart problems	☐ yes	☐ no	Frequent sore throats	☐ yes	☐ no
Asthma	☐ yes	☐ no	Bladder problems	☐ yes	☐ no	Nosebleeds	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Cancer	☐ yes	☐ no	Backaches	☐ yes	☐ no
Eczema/rashes	☐ yes	☐ no	Headaches/migraines	☐ yes	☐ no	Frequent urination	☐ yes	☐ no
ADD/ADHD	☐ yes	☐ no	High blood pressure	☐ yes	☐ no	Kidney disease	☐ yes	☐ no
Sickle cell disease/trait	☐ yes	☐ no	Fainting	☐ yes	☐ no	Shortness of breath	☐ yes	☐ no
Pounding of heart	☐ yes	☐ no	Pneumonia	☐ yes	☐ no	Learning Disability	☐ yes	☐ no

Student's Daily Medications? ____

Condition for Medications? ____

Any Medication Allergies? ____

Any Food Allergies? ____

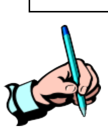
Any Surgeries? ____

Any Hospitalizations? ____

Daily medicines **will not** be dispensed at the clinic. They will be dispensed at the office.

Other health problems? ____

Parental consent is required for the following medical and mental health services provided the student/patient is under the age of 18:	**Current Michigan Law allows for confidential services, without Parental Consent, to Minors and student over 18 in these areas:**
➢ Nursing screenings, assessment, and care ➢ Minor injury treatment ➢ Nursing assessment of risk behaviors. ➢ Coordination of chronic disease management, in partnership with the school and primary care provider ➢ Referrals for primary care, oral health care, and other specialty care ➢ Possible administration of the following medication through established protocols developed by the BLDHD Medical Director: Acetaminophen, Ibuprofen, Antihistamine (Benadryl), Triple antibiotic ointment, Hydrocortisone cream, cough drops, antacid, eye drops, for the SWP. ➢ Mental health services for children under age 14 (individual, family, and group), and those 14 and older following 12 visits (or 4 months) allowed by law to minors.	For Students 12 years or older: ➢ Family planning services, including pregnancy testing and referrals ➢ Sexually transmitted disease screenings, treatment, and counseling ➢ HIV screening and referrals ➢ Substance-use services and counseling ***For students 14 years or older** ➢ Any Mental health assessment, counseling, crisis intervention, and/or referrals ➢ *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 US Armed Forces provide consent for services themselves.* ➢ **A separate minor consent form is used with the above services** **Please note:** Students can access these services confidentially, at these ages, at ANY clinic, not just a school-based wellness center or program.



By signing this consent form, I certify that I am the parent/legal guardian of the student named above and am registered with the school as such.

Signature of Parent/Guardian____ **Date**: __________