Benzie-Leelanau District Health Department
Caring for our Communities

Husky Health and Wellness Center (HHWC)
Student Health Information and Consent

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

Name (Last Name, First Name, M.I.)	Birth Date	Age	Grade	School

Address	City	Zip Code	Student Telephone	Today's Date

Race/Ethnicity (optional)	Gender (male, female, other, decline)

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.)			
Address	City	State	Zip Code

I consent to all the following:

- The above named may receive services at the Husky Health and Wellness Center (HHWC) 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- This consent remains active until rescinded, or the student reaches age 18.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 a signed parent/guardian consent won't be seen, except for an emergency or student's first visit to HHWC Nurse, when staff will call the parent/guardian before providing any services, for a one-time-only verbal consent.
- **I understand that the HHWC and my child's primary provider may exchange health information for continuity of care.**
- I authorize the HHWC to disclose protected health information from a visit for continuation of treatment, and internal peer review audit.
- I authorize the HHWC to release information regarding treatment and care to the following: HHWC 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**.
- I understand that HHWC 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 HHWC services.**
- *I understand that these services are provided only at the following Schools:* ***Benzie Middle and High School, Crystal Lake Elementary, and Benzie Academy.***

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 CAHC program requirements include abortion counseling and referral; or prescribing and dispensing of family planning medications and devices.

OVER (COMPLETE BOTH PAGES OF THIS FORM

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 County, 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? _____
Other health problems? _____

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

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 ➢ Emergency care and 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 HHWC. ➢ 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.

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**: _____