PETOSKEY SCHOOL WELLNESS PROGRAM

Petoskey Middle School: 801 Northmen Dr., Petoskey, MI 49770
Petoskey High School: 1500 Hill St., Petoskey, MI 49770
School Wellness Nurse: (231) 412-6371
Behavioral Health Therapist: (231) 412-6459

Parent/Guardian/Adult Consent for Services

STUDENT INFORMATION

Name: _____ Preferred Name: _____ Date of Birth: _____ Age: _____

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:

Relationship: _____ Email: _____

Parent/Guardian Name: _____ Phone: _____ Legal Custody:

Relationship: _____ Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

SERVICES AVAILABLE

NURSING: A school nursing assessment and care for minor injury and illness, administering limited over-the-counter medication, coordinating care and chronic disease management with the school and primary care provider, providing basic laboratory services/tests, immunization outreach to parent/guardian if student is due, providing referrals to establish primary care and oral healthcare providers, assessing mental health and risk behaviors, and Medicaid outreach and enrollment.

MENTAL HEALTH: 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. *Limited telehealth services with a primary care provider are available for acute conditions which are identified through nurse-initiated CLIA lab testing and other clinical guidelines. A maximum of two telehealth appointments with a distant provider are available per day.*

Do you need help with insurance? You can apply for Medicaid coverage (and MI Child) at any time throughout the year.

For more information or to apply visit: https://newmibridges.michigan.gov

If you need assistance with your application, please let us know. We are here to help!

CONSENT

Parents/Guardians must provide consent for their minor children for services at the Petoskey School 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*, pregnancy testing and referrals, sexually transmitted disease screenings, testing, treatment and counseling, HIV screening, testing and referrals for treatment. Please note: Students can access these services confidentially at ANY clinic, not just a school-based health center program. 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 I give consent for the following services: (check one)

☐ Mental health **AND** nursing services ☐ Mental health services **ONLY** ☐ Nursing services **ONLY**

I agree that I have reviewed and understand the Petoskey School Wellness Program services stipulated above. This consent does not need to be renwed 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:

- I authorize the PSWP to exchange health information with my child's primary care provider for continuity of care. I further authorize Public Schools of Petoskey to provide a copy of my child's emergency card to the AHC PSWP annually.
- Family planning services are not offered at this clinic. No birth control pills or devices are dispensed or prescribed. No abortion counseling, services or referrals are provided.
- ***Notice regarding attendance:*** *For student safety, visit attendance is shared with the school's front office. This is the only information provided. No medical/behavioral health notes or reasons for the visit are ever disclosed. Attendance records are shared solely to ensure student safety during emergency procedures (ex. Lockdown drills) and to prevent students from being marked absent.*
- Parental consent is NOT needed for crisis intervention and emergency care.

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

AHC Alcona health center

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- _____ My initials indicate that I have been offered a copy of AHC's Notice of Privacy Practices. The notice is available at www.alconahealthcenters.org. We will be happy to provide you with a paper copy upon your request.
- I authorize the AHC Petoskey School Wellness Program to bill my insurance for services provided to my child and to release information regarding treatment of my child to third party payers (insurance companines, other health plans) for the purposes of payment for services.

STUDENT INSURANCE INFORMATION

☐ No insurance (uninsured)	
☐ Medicaid/Medicaid HMO	
☐ Blue Cross Blue Shield	
☐ Blue Care Network	
☐ Priority Health	
☐ TriCare	
Other:	

CONTACT ME FOR INFORMATION REGARDING

- ☐ Health insurance options
- ☐ Finding a Healthcare Provider
- ☐ Finding a Dentist
- ☐ Paying for medical bills
- ☐ Emotional well-being of child/adult in my home
- ☐ Paying for transportation to Healthcare Provider
- ☐ Help paying for heat/water/utility bills
- ☐ Shelter ☐ Food ☐ Clothing

STUDENT HEALTH INFORMATION

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
- ☐ Autoimmune disorders
- ☐ Anemia
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Developmental Disorders
- ☐ Developmental Disabilities
- ☐ Physical/sexual/other trauma
- ☐ Anxiety
- ☐ Asthma
- ☐ Trouble Sleeping
- ☐ Abnormal Mood Swings
- ☐ Seizures
- ☐ Lukemia
- ☐ Cognitive Impairment
- ☐ Other: _____
- ☐ Unexplained Tiredness
- ☐ Persistent Cough
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss
- ☐ Stomach or Bowel Problems
- ☐ Depression
- ☐ Headaches
- ☐ Shortness of Breath
- ☐ Head, Eyes, Ears or Throat Problems
- ☐ Blood Transfusions
- ☐ Anaphylatic Episodes
- ☐ Chest Pain
- ☐ Joint or Muscle Pain or Stiffness
- ☐ Eating Concerns

Please describe anything checked above: _____

Serious injuries or Illness (describe): _____
Surgies (reason/date): _____
Hospitalizations (reason/date): _____
Student's Doctor: _____ Phone: _____
Student's Dentist: _____ Phone: _____

FAMILY MEDICAL HISTORY

Please check if any of the student's blood relatives (mother/father/sibling/grandparent) have any of the following conditions:

- ☐ HIV/AIDS
- ☐ Autoimmune disorders
- ☐ Anemia
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Developmental Disorders
- ☐ Anxiety
- ☐ Asthma
- ☐ Trouble Sleeping
- ☐ Abnormal Mood Swings
- ☐ Seizures
- ☐ Lukemia
- ☐ Unexplained Tiredness
- ☐ Persistent Cough
- ☐ Unexplained Weight Gain
- ☐ Unexplained Weight Loss
- ☐ Stomach or Bowel Problems
- ☐ Depression
- ☐ Shortness of Breath
- ☐ Head, Eyes, Ears or Throat Problems
- ☐ Blood Transfusions
- ☐ Anaphylatic Episodes
- ☐ Chest Pain
- ☐ Joint or Muscle Pain or Stiffness

*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