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 Line: (231) 412-6371

Consent for Care

_____ _____
(Child's name) *(Child's date of birth)*

_____ _____ _____
(*Sex, optional)* *(Preferred Pronoun, optional)* *Student's Telephone*

Race/Ethnicity (optional)
□ **Black/African American** □ **White** □ **Hispanic/Latin** □ **American Indian/Alaskan Native** □ **Asian** □ **Native Hawaiian/Pacific Islander**

The AHC Petoskey School Wellness Program (PSWP) is a school-based program located at Petoskey Middle and High School. The program serves children ***5-21 years of age*** who reside in the Public Schools of Petoskey district primarily. PSWP is managed and staffed by Alcona Citizens for Health, Inc.

The center provides comprehensive nursing services including, but not limited to:

- *Screening/nursing assessments, case finding, immunization assessment and administration, first aid for minor injuries, chronic care intervention, hearing and vision screening, blood pressure monitoring, blood glucose monitoring, case management, dispensing over-the-counter (OTC) medications under medical director standing orders, administration of prescribed medications with a doctor's order, and/or referral to other needed primary care and specialty medical services. Behavioral Health services are also offered under this program, but require a separate consent form.* ***If interested in Behavioral Health services, please ask the PSWP staff for the necessary forms.***
- *Confidential Services: I understand that State law allows certain confidential services for students. These include 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.*

I understand that the PSWP will be obtaining height and weight information annually on my child. PSWP Staff use this information to promote healthy weight and lifestyle habits for your child. I understand that a confidential risk assessment survey will be given to all students and/or parents/guardians. I understand that the PSWP will attempt to contact me when services are provided and will notify me in writing when services are provided if the center has been unable to reach me by phone. I have been given a copy of my child's rights and responsibilities at the center**. I understand that this consent form will remain valid until my child reaches age 18 unless I withdraw it by submitting a Withdrawal of Consent form. I understand the services offered at the AHC PSWP.**

I give my consent for treatment and authorize PSWP staff to provide services to my child.
I authorize the PSWP to bill my insurance for services provided to my child and to release information regarding treatment of my child to third party payers (insurance companies, other health plans) for purposes of payment for services. 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.

Please Note:

- *Services provided in the PSWP are billed the same way they would be if these services were provided at AHC. Unless you indicate otherwise on the consent form, you will be contacted* ***PRIOR*** *to a billable service being delivered to your child. PSWP offers a sliding fee program.* ***Nobody will be turned away for inability to pay.***
- *Family planning services are not offered at this clinic. No birth control pills or devices are dispensed or prescribed. No abortion counselling, services or referrals are provided.*

-Over

Child's Insurance Information:

Insurance company: _____ ID Number: _____

Name of Insured: _____DOB of insured: _____

Child's relationship to insured: _____

Emergency Contact Information:

Home Address: _____

Home Phone Number: _____ Parent Cell Number: _____

Mother (guardian) Name: _____ Employer Phone Number:_____

Father (guardian) Name: _____ Employer Phone Number:_____

Primary Care Provider or Office_____

Primary Care Provider Telephone Number: _____

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!

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

_____ _____ _____

(Printed name of parent or guardian) (Signature) (Date)

_____ **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.