AHC Owl Health Extension

Richardson Elementary School, 3630 E. River Rd., Oscoda, MI 48750, (989) 569-6002

Consent for Care

_____ _____

(Child's Name) (*Child's Date of Birth*)

_____

(Student's Telephone Number)

Race/Ethnicity (optional)

☐ White/Caucasian ☐ Black/African American ☐ Native American ☐ Asian ☐ Native Hawaiian/Pacific Islander

The AHC Owl Health Extension is a school-based health center located at Richardson Elementary School. The center serves children ***3-21 years of age*** who reside in the Oscoda Area Schools district primarily. The AHC Owl Health Extension is managed and staffed by Alcona Citizens for Health, Inc.

The center provides comprehensive health care including, but not limited to:

- *Well/annual visits, immunizations, acute care, care for chronic conditions, administration of medications prescribed by a primary care provider, over-the-counter medication dispensing, and first aid services. Behavioral Health Services are also offered at the Owl Health Extension, but require a separate consent form.* ***If interested in Behavioral Health Services, please ask the Owl 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 AHC Owl Health Extension will be obtaining height and weight information annually on my child. Owl 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 AHC Owl Health Extension 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 Owl Health Extension.

I give my consent for treatment and authorize AHC Owl Health Extension staff to provide services to my child. I authorize the AHC Owl Health Extension 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 AHC Owl Health Extension to exchange health information with my child's primary care provider for continuity of care. I further authorize Oscoda Area Schools to provide a copy of my child's emergency card to the AHC Owl Health Extension annually.

Please Note:

- *Services provided in the Owl Extension 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. AHC Owl Health Extension offers a sliding fee program.* ***Nobody will be turned away for inability to pay.***

- TURN OVER-

- *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.*

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 Phone Number: _____

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.**