Owl Health Extension

Parent/Guardian Consent Form Clinical Services

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

Race/Ethnicity (optional)

□ Black/African American □ White □ Hispanic/Latin □ American Indian/Alaskan Native □ Asian □ Native Hawaiian/Pacific Islander

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 Student's Physician/Clinic		Telephone #	
Name of Student's Dentist		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 of the following:
- The above named may receive services at the Owl Health Extension by the Nurse Practitioner and Behavioral Health Therapist.
- This consent remains active until rescinded or the student reaches age 18.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 the Owl Health Extension and my child's primary provider may exchange health information for continuity of care.
- I authorize the Owl Health Extension to disclose protected health information from a visit for continuation of treatment, operations and internal peer review audit.
- I authorize the Owl Health Extension to obtain my student's academic, discipline, and absence data for program evaluation purposes.
- I understand that a confidential risk assessment survey will be given to all students and/or parents.
- I understand that Behavioral Health visits are charged a fee and that my insurance company will be billed for services. I understand that I will be responsible for any fee not covered by my insurance company and that it is my responsibility to be aware of these fees. Alcona does provide a sliding fee scale. please ask if you would like more information on this service.
- I understand that State law allows <u>certain</u> confidential services for students that meet age criteria (see page 2)
- I understand that I am under no obligation to have my child use the Owl Health Extension services.
- I understand that

By signing the back of 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.

-Over-

Student Medical History: 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
Depression	☐yes	☐no	Anxiety	☐yes	☐no			

Does anyone smoke in the household? ☐yes ☐no

Student's Daily Medications? _____
Condition for Medications? _____
Any Medication Allergies? _____
Any Food Allergies? _____
Any Surgeries? _____
Any Hospitalizations? _____
Other health problems? _____

Family Medical History Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them	
☐ Heart Problems	☐ Cancer
☐ Cholesterol	☐ Diabetes (high blood sugar)
☐ High Blood Pressure	☐ Stroke
☐ Asthma/Emphysema/Bronchitis	☐ Seizures
☐ Death under age 50 – Cause:	☐ Kidney or Thyroid Disease
☐ Sickle Cell Anemia/Blood problems	☐ Other

Parental consent **is required** for the following services provided the student/patient is under the age of 18:	**Current Michigan Law allows for confidential services to minors in these areas:**
➢ Treatment for acute & chronic illness & injuries ➢ Immunizations ➢ Basic laboratory services & tests ➢ Individual, group, family counseling ➢ Referrals for specialty services ➢ Possible administration of the following medication: Acetaminophen, Ibuprofen, Antihistamine, Benadryl, Triple anti-biotic ointment, Hydrocortisone crème, cough drops, antacid, eye drops and 1% Permethrin for head lice.	For Students 12 years or older: ➢ Pregnancy testing and referrals ➢ Sexually transmitted disease screenings, treatment and counseling ➢ HIV screening and referrals For students 14 years or older ➢ Any Mental health assessment, counseling and/or referrals **Please note:** Students can access these services confidentially, at these ages, at ANY clinic, not just a school-based health center program.

Parental consent is NOT needed for crisis intervention and emergency care

LIMITATION OF SERVICES: NO birth control pills, or devices will be dispensed or prescribed; NO abortion counseling, referrals or services are provided.

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

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 apply online at www.michigan.gov/mibridges