

Petoskey School Wellness Program

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 Petoskey School Wellness Program by the Registered Nurse.
- This consent remains active until rescinded or the student reaches age 18.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 Petoskey School Wellness Program and my child's primary provider may exchange health information for continuity of care.
- I authorize the Petoskey School Wellness Program to disclose protected health information from a visit for continuation of treatment, operations and internal peer review audit.
- I authorize the Petoskey School Wellness Program 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 State law allows certain 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 Petoskey School Wellness Program 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	<input type="checkbox"/> yes	<input type="checkbox"/> no	Seizures (epilepsy)	<input type="checkbox"/> yes	<input type="checkbox"/> no	Psychological disorder	<input type="checkbox"/> yes	<input type="checkbox"/> no
Anemia	<input type="checkbox"/> yes	<input type="checkbox"/> no	Stomach problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Thyroid disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
Seasonal allergies	<input type="checkbox"/> yes	<input type="checkbox"/> no	Heart problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Frequent sore throats	<input type="checkbox"/> yes	<input type="checkbox"/> no
Asthma	<input type="checkbox"/> yes	<input type="checkbox"/> no	Bladder problems	<input type="checkbox"/> yes	<input type="checkbox"/> no	Nosebleeds	<input type="checkbox"/> yes	<input type="checkbox"/> no
Diabetes	<input type="checkbox"/> yes	<input type="checkbox"/> no	Cancer	<input type="checkbox"/> yes	<input type="checkbox"/> no	Backaches	<input type="checkbox"/> yes	<input type="checkbox"/> no
Eczema/rashes	<input type="checkbox"/> yes	<input type="checkbox"/> no	Headaches/migraines	<input type="checkbox"/> yes	<input type="checkbox"/> no	Frequent urination	<input type="checkbox"/> yes	<input type="checkbox"/> no
ADD/ADHD	<input type="checkbox"/> yes	<input type="checkbox"/> no	High blood pressure	<input type="checkbox"/> yes	<input type="checkbox"/> no	Kidney disease	<input type="checkbox"/> yes	<input type="checkbox"/> no
Sickle cell disease/trait	<input type="checkbox"/> yes	<input type="checkbox"/> no	Fainting	<input type="checkbox"/> yes	<input type="checkbox"/> no	Shortness of breath	<input type="checkbox"/> yes	<input type="checkbox"/> no
Pounding of heart	<input type="checkbox"/> yes	<input type="checkbox"/> no	Pneumonia	<input type="checkbox"/> yes	<input type="checkbox"/> no	Learning Disability	<input type="checkbox"/> yes	<input type="checkbox"/> no
Does anyone smoke in the household?	<input type="checkbox"/> yes	<input type="checkbox"/> 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	
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Diabetes (high blood sugar)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Death under age 50 – Cause:	<input type="checkbox"/> Kidney or Thyroid Disease
<input type="checkbox"/> Sickle Cell Anemia/Blood problems	<input type="checkbox"/> Other

<p>Parental consent is required for the following services provided the student/patient is under the age of 18:</p> <ul style="list-style-type: none"> ➤ 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. 	<p>Current Michigan Law allows for confidential services to minors in these areas:</p> <p>For Students 12 years or older:</p> <ul style="list-style-type: none"> ➤ Pregnancy testing and referrals ➤ Sexually transmitted disease screenings, treatment and counseling ➤ HIV screening and referrals <p>For students 14 years or older</p> <ul style="list-style-type: none"> ➤ Any Mental health assessment, counseling and/or referrals <p>Please note: Students can access these services confidentially, at these ages, at ANY clinic, not just a school-based Petoskey School V Program.</p>
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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