UPPER GREAT LAKES FAMILY HEALTH

Houghton-Portage Township Elementary School Wellness Program
203 W. Jacker Ave. Houghton, MI 49931 (906) 482-0456

Houghton-Portage Township Elementary School Wellness Program
Parent/Guardian Consent for Services Form

All services are provided in compliance with Federal, Michigan and Michigan Minor Consent Laws

Student Name (last, first, middle initial):			**Date of Birth:**
Age:	**Gender: Male ☐ Female ☐**	**Grade:**	**Phone Number:**
Home Address:			
Email Address:			
Race/Ethnicity: ☐ Black/African American ☐ White ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Hispanic/Latin			
Parent(s)/Guardian(s) Name:			**Phone Number:**
Primary Care Provider:			**Phone Number:**
Insurance: ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Other:			
Policy/ID #	**Subscriber Name/Relationship to Student:**		**Subscriber Date of Birth:**

Daily Medications: Please list any medications the student takes regularly.

Name of Medicine	Dose (mg)	Frequency	Name of Medicine	Dose (mg)	Frequency
1.			3.		
2.			4.		
Allergies to Medications:					

Over the Counter (OTC) Medications: Please indicate if your child may receive over the counter (OTC) medications as needed.

	Yes	No
Acetaminophen (Tylenol)		
Ibuprofen / Motrin		
Benadryl		

Student Health History: Please X the YES column if any of these conditions apply.

Condition:	YES	Condition:	YES	Condition:	YES	Other Conditions:
Bee Sting Allergies		Seizure/Epilepsy		ADD/ADHD		
Food Allergies		Anemia		High Blood Pressure		
Seasonal Allergies		Stomach Problems		Fainting		
Do you carry an Epi-Pen?		Heart Problems		Shortness of Breath		
Asthma		Bladder Problems		Frequent Urination		
Diabetes		Skin Disorders		Blood Disorders		

Please read the following statements and be sure that you understand each as written:

- I give consent for my child to receive services at the Houghton Elementary School Wellness Program by the Registered Nurse (RN) and Behavioral Health Practitioner upon request. Services include, but are not limited to: screening/nursing assessments, first aid for minor injuries, chronic care interventions, case findings, hearing and vision screening, blood pressure monitoring, blood glucose monitoring, case management, dispensing over the counter (OTC) medications under medical director standing

orders, immunization assessment (review of record), point of care lab testing for Influenza, RSV, Strep and COVID-19, and/or referra to other needed primary care and specialty medical services. Behavioral Health services are available upon request/referra

- I understand that parental consent is **not** needed for crisis intervention or emergency care.
- I understand that the School We lness Program staff will attempt to contact me by phone should my child receive services. I further understand that staff will use their judgement (example: sending a note home with my child verse a phone call for a band aid) unless otherwise indicated to staff.
- I understand that all services are provided in compliance with Federal, Michigan, and Michigan Minor Consent Laws. Under Michigan State Law, minors twelve (12) years of age or older can, without parental/legal guardian consent, receive advice, testing, and/or treatment for substance abuse, family planning counseling services, sexually transmitted disease, and HIV, which are defined as Confidential Services. **Please note, although the School Wellness Program does not provide pregnancy testing, STD, or HIV Testing, by Michigan State Law, students can access these services confidentially, at these ages, at any outside clinic. I further understand that Family Planning Services are not offered by the School Wellness Program. No birth control, pills, or devices are dispensed or prescribed. No abortion counseling, services, or referrals are provided.** Under Michigan State Law, minors fourteen (14) years of age and above can, without parental/legal guardian consent, obtain outpatient mental health services, not to exceed twelve (12) visits over four (4) months and not to include medications.
- I authorize the Schoo Wellness Program and my child's primary care provider to exchange health care information, should it be necessary, for the purpose of continuity and coordination of care. I authorize the School Wellness Program to obtain a copy of my child's immunization record from MCIR, the school office, and/or the loca health department and make updates as needed.
- I understand that immunization administration is not covered under this consent and additional consent would need to be completed and provided to the School Wellness Program Staff prior to those services being rendered.
- I understand that as an entity of Upper Great Lakes Family Health Center, the School Wellness Program participates in and recognizes the rules of the Health Information Portability and Accountabil ty Act (HIPAA). I acknowledge that a copy of Upper Great Lakes Family Health Center's **Notice of Privacy Practices** is available at www.uglhealth.org or paper copy upon request.
- I understand that a confidential risk assessment survey will be given to all students and/or parent/legal guardian.
- I understand that this consent remains valid for one (1) academic school year unless I withdraw by submitt ng a Withdrawal of Consent Form, or my child reaches the age of eighteen (18).

Financial Responsibility

We accept and bill insurance for any scheduled visit by a **behavioral health provider**, however, no fees are required at the school site. Co-pays and deductibles are based on the student's insurance and no student is ever turned away for inability to pay. Our staff can assist students and their families with Medicaid Enrollment and/or Upper Great Lakes Family Health Center Sliding Fee Discount Program.

- I acknowledge that a copy of Upper Great Lakes Family Health Center's **Sliding Fee Discount Program** is available at www.uglhealth.org or paper copy upon request.

By signing this consent, I certify that I am the legal guardian of the above listed child and have read and understand the above information provided.

Parent/Guardian Printed Name	**Parent/Guardian Signature**	**Date**