Cherry Health
Comprehensive. Quality. *Healthcare.*

School Based Health Center Consent Form

Student Name:	Date of Birth:
School:	Grade:

Services Provided

- Physical exams for school, sports and camp
- Treatment for acute, chronic illness and injuries
- Vision / hearing screenings and followup
- Dental exams, cleanings and x-rays
- Immunizations
- Basic laboratory services and tests
- Crisis intervention *
- Administration of medication
- Referrals for specialty services
- Substance use education, counseling and referrals *
- Individual, group, family and community education
- Mental health and psychosocial assessment, counseling and referrals *
- STD and screening checks *
- Pregnancy testing *
- HIV testing *
- Telehealth services/virtual visits
- Community Health Worker services

*** Current Michigan law states that these services do not require parental consent.**

Services NOT Provided:
No birth control pills or devices are dispensed or prescribed. No abortion counseling, referrals or services provided.

If you want your child to receive any of the following services, **please place a checkmark at the consent checkbox next to each service. Please sign and date the bottom of the form, on the second page and return this form to your child's school.**

Medical Care

☐ **I consent for my child or myself to receive medical care** through the School Based Health Center.
Please note: Additional documentation is required for the administration of vaccines.

Does your child have health insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other health insurance (Please list the name of insured parent, name of insurance and policy #):

Dental Care

☐ **I consent for my child or myself to receive dental care** through the School Based Health Center.

Does your child have dental insurance? ☐ Yes ☐ No	Does your child have Medicaid? ☐ Yes ☐ No	Medicaid #:

Other dental insurance (Please list the name of insured parent, name of insurance and policy #):

Where do you take your child to see the dentist?	Phone #:	Date of last exam:

Counseling Services

☐ **I consent for my child or myself to receive counseling, community health worker services and/or psychiatric care** (Examples: one-on-one counseling, health education skill counseling, community resource referrals and outreach and coordination of outside resources and/or services, assessments and medication reviews.)

Health History

Where do you take your child to see the doctor?	Phone #:	Date of last exam:
List of allergies to medications, food, bee stings, etc:	List current medications your child is taking:	Pharmacy:
Does the child have any medical problems including learning or physical disabilities? ☐ Yes ☐ No	If yes, please list:	
Does the child's siblings or parents have any medical problems or history of cancer? ☐ Yes ☐ No	If yes, please list:	
Has your child ever been a patient in the hospital overnight? ☐ Yes ☐ No	If yes, why?	
Has your child ever had any surgeries? ☐ Yes ☐ No	If yes, describe:	Has your child ever been hospitalized for a heart problem? ☐ Yes ☐ No

Patient name:	DOB:	Grade:

Parent / Guardian Information

Mother/Guardian:	DOB:	Home/work phone:
Father/Guardian:	DOB:	Home/work phone:

Parent/Guardian address:

Email address:

Emergency contact:	Relationship:	Phone #:

Household annual income:	# of people in household:	What language is most often spoken at your home?

Is there any other important information we should know?

Would you like to request any other assistance, or have any comments to help the health center serve you better?

Additional Information

Please check the box that best describes your child's race:

☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ More Than One Group
☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Declined to specify ☐ Unknown

Please check the box that best describes your child's ethnicity:

☐ Latino or Hispanic ☐ Not Latino or Hispanic ☐ Decline to specify

Please check the box that best describes your child's current housing situation:

☐ Doubling Up (living with extended family, friends or acquaintances)
☐ Not Homeless (legally occupied, single family, owned or rented)
☐ Street (on the street, in cars, abandoned buildings, under bridge)
☐ Transitional (treatment program, hospital, jail, motel)
☐ Shelter
☐ Other
☐ Unknown/Unreported

Select Yes or No based on your family's primary source of income:

1. In the last 24 months, have you worked on a farm/orchard planting or harvesting crops? ☐ Yes ☐ No

If you answered No, you may skip the next 3 questions.

1. In order to work in agriculture, have you moved during the past 3 years? ☐ Yes ☐ No
2. Due to the seasonal nature of your work in agriculture, have you had to change jobs, reduce the number of hours you work, or been temporarily been laid off during the past 2 years? ☐ Yes ☐ No
3. Have you or family you live with, stopped working in agriculture due to disability or old age? ☐ Yes ☐ No

By signing this consent, I confirm I am the parent/legal guardian of the above listed student and am authorized to give this consent. This consent will be in effect for one year from this date.

Parent/Guardian or student if over 18 years Signature:	Date:

In order for health center staff members to provide services, I authorize the school to release school records on a "need to know basis" to the School Based Health Center staff members, and also for the School Based Health Center staff members to release medical records to the school and my health care provider as needed to assist in the treatment and/or continuity of care for my child. These records may include the following; immunization records, class schedules, parental contact, address, phone number, medical and behavioral health conditions, health screenings, medications, health care plans, or attendance information. The medical and mental health providers from the School Based Health Center may participate in student success or attendance teams if needed. I also authorize other health care providers for the student listed above to release information to the School Based Health Center staff members as needed. This information may include the following; medical records including lab results, office visits, hospital admissions, vaccinations and BMI (Body Mass Index) information entered into MCIR (Michigan Care Improvement Registry), dental and mental health records. I hereby authorize the School Based Health Center to provide the services as indicated above. I understand that my insurance company, if I have coverage, will be billed for services rendered. All students are served regardless of the ability to pay. I hereby authorize the School Based Health Center staff members to release any medical records required by the insurer to obtain payment. Following Health Insurance Portability and Accountability Act (HIPAA) rules, School Based Health Center staff members will use and share my Personal Health Information (PHI) for: 1) treatment of my child's health condition and maintaining the continuity of my child's care, 2) payment for health services provided to my child, and 3) routine health care operations including quality improvement, accreditation, educational purposes, or other disclosures as required by law. I understand that The Notice of Privacy Practices document is available to me at the location(s) my child receives their health care services and on the Cherry Health website.