Cherry Health

E-3 School-Based Consent
Counseling and Community Health Worker Services

Student's name: _____ Date of birth: _____

School: _____ Grade: _____

Services provided:

- Individual, group, family and community education
- Mental health services, including screening, assessment, counseling and referrals
- Health education
- Substance use referrals
- Telehealth Services/Virtual visits
- Skills coaching

If you want your child to receive counseling services, please check the "consent box," sign and date the bottom of this page and return this form to your child's school.

Counseling Services

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

Does your child have health insurance? ☐**Y** ☐**N**

Health insurance (choose one):

☐ Medicaid #: _____

☐ Insured: _____
Name of insured parent, insurance name and policy #

☐ Other: _____

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 health information we should know? _____

Additional Information

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

□ American Indian/Alaskan Native □ Asian □ Black/African American
□ More Than One Group □ Native Hawaiian □ Other Pacific Islander
□ White □ Decline to specify □ Unknown

Please check the box that best describes your ethnicity:

□ Latino or Hispanic □ Not Latino or Hispanic □ Decline to specify

Please check any box that 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

***Flip over and complete the back side of this form**

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Please circle Y or N based on you or your family's primary source of income:

1. In the last 24 months have you worked on a farm/orchard planting or harvesting crops? Y N

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

1. In order to work in agriculture, have you moved during the past 2 years? Y N
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 laid off during the past 2 years? Y N
3. Have you or family you live with stopped working in agriculture due to disability or old age? Y N

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 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 his/her health care services and on the Cherry Health website.