School Based Health Center
Consent for Medical Services

Services Provided

The client has the right to refuse to defer treatment unless intent exists to harm self or others

Parental Consent is required for the following services provided to patients under the age of 18:

- Mental health counseling/psycho-social assessment, and referral (ages 14-17 if receiving more than 12 sessions or 4 months as a confidential service.
- Health maintenance Exams/Well Child Care/Risk Assessments
- Physical/EPSDT exams for school, sports, camp and work
- Treatment for acute and chronic illnesses and injuries
- Tele-health services
- Vision/hearing/diagnostic screenings and follow up
- Oral/dental screenings and follow up Immunizations
- Basic laboratory services and tests
- Medication administration
- Individual, group, family and community health education
- Referrals for specialty services Michigan law allows for confidential services to minors aged 12 and up.

Parental consent is not required for:

- Pregnancy testing/services, birth control referrals
- Sexually Transmitted Infection screenings treatment/ counseling, testing
- HIV counseling, testing, treatment, and referrals
- Substance abuse education, counseling, and referrals
- Mental Health and psycho-social assessment, counseling, and referral (must be 14+ to consent- up to 12 sessions or 4 months of care (whichever comes first)

Services NOT Provided

Per Michigan Law:

- Birth control pills and contraceptive devices are not dispensed or prescribed on school premises.
- Abortion counseling, referrals, or services are not provided.

Parent/Guardian Consent

I consent to the following:

- The named student may receive all services listed above at the Child and Adolescent Health Centers.
- Exchange of healthcare information between the Child and Adolescent Health Centers and the student's primary care physician and other established healthcare providers for continuity and coordination of care according to state and federal laws.
- Release of information regarding treatment to third party payers or others for the purpose of receiving payment for services.
- In certain situations, the delivery of care may include telemedicine:
    - My health care provider has explained how the video conferencing technology will be used to affect consultation. I understand that this consultation will not be the same as a direct patient/health care provider visit since I will not be in the same room as my health care provider.
    - I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consultation if it is felt that the videoconferencing connections are not adequate for the situation.
    - I understand others may also be present during the consultation other than my health care provider and consulting health care provider to operate the video equipment. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.

By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the above-named student, and the insurance information is current and correct. I understand that I may withdraw my consent or refuse services upon written notice to the health center at any time. (Withdrawal notification can be written directly on this consent form.)

Additionally, by checking each box below, I consent to the following:

☐ The above-named student may receive COVID-19 evaluation, testing and treatment by the School-Based Health Center. All students who have received COVID-19 testing through the School-Based Health Center will have results communicated to the parent/guardian as well as school administration prior to returning to school. I understand that positive test results require reporting to the Oakland County Health Department.

☐ Immunizations – I understand my child's immunization records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. If it is determined that my child needs a shot, I give my permission for it to be given at the School-Based Health Center, and I give permission that the administration of the vaccine be recorded in the MCIR. I understand that I will be able to review a written description of the vaccine and/or talk with a vaccine administrator prior to the vaccine being given.

Student Full Name: _____ Date: _____

Primary Parent/Guardian Signature: _____ ***OR*** *Student Signature (18+ ONLY):* _____

Secondary Parent/Guardian Signature *(**If applicable):* _____

Student Information

Last Name		First Name		Middle Initial			
Date of Birth		Social Security #		Student Cell Phone			
Age		Sex	☐ Female ☐ Male ☐ Choose not to disclose				
Grade		School					
Address		City		State		Zip Code	

Race	☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African	☐ Native Hawaiian/Pacific Islander ☐ White ☐ More than one race ☐ Not listed/Choose not to disclose
Ethnicity	☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Guamanian/Chamorro ☐ Asian Indian ☐ Chinese ☐ Filipino	☐ Japanese ☐ Korean ☐ Vietnamese ☐ More than one ethnicity ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Another Asian ethnicity ☐ Not listed/Choose not to disclose
Preferred Language	☐ English ☐ Spanish ☐ Other (please specify): _____	
Living Situation	☐ Not Homeless (Family owns/rents a home/apartment) ☐ Homeless	
	Are you worried about losing your housing?	☐ Yes ☐ No

Primary Parent/Legal Guardian Information

Last Name		First Name					
Date of Birth		Social Security #					
Phone Number		Preferred Language					
Address		City		State		Zip Code	

Secondary Parent/Legal Guardian Information ***If applicable*

Last Name		First Name					
Date of Birth		Social Security #					
Phone Number		Preferred Language					
Address		City		State		Zip Code	

Emergency Contact Information *(Complete only if contact is NOT a parent/legal guardian)*

Last Name		First Name	
Phone Number		Relationship to Student	

Student Health History

Student's Primary Care Physician (PCP)		PCP Phone #	
Date of Last Physical Exam	_____/_____/_____ ☐ I do not remember		
Student's Dentist		Dentist Phone #	

Current Medications	***Please include dosage and reason for taking medication** Medication: _____ Dose: _____ Reason: _____ Medication: _____ Dose: _____ Reason: _____
Allergies	***Please select all that applies and list where indicated** ☐ Seasonal (dust, hay fever, etc.) ☐ Food: _____ ☐ Bee Stings ☐ Other: _____ ☐ Medication: _____

Please check if you (student) have any of the following

☐ Anemia	☐ Asthma	☐ Attention Deficit Disorder	☐ Blood Disease
☐ Cancer	☐ Dental Problems: _____	☐ Diabetes	☐ Mental Illness
☐ Fainting	☐ Headaches/Migraines	☐ Head Injury	☐ Heart Murmur
☐ Heart Problems: _____	☐ HIV/AIDs	☐ Hypertension (high blood pressure)	☐ Jaundice
☐ Kidney/Bladder/Urine Problem	☐ Liver Disease	☐ Menstrual Problems: _____	☐ Pregnancy, Due: _____
☐ Rheumatic Fever	☐ Seizures (with or w/o epilepsy)	☐ Sickle Cell Trait	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Skin Problems	☐ Stomach Problems	☐ Venereal Disease

Other health issues/problems not listed: _____

Family Medical History: *Check if any of the student's relatives had any of the following illnesses and note which relative*

☐ Asthma	Who: _____	☐ Hypertension (high blood pressure)	Who: _____
☐ Anxiety other	Who: _____	☐ High Cholesterol	Who: _____
☐ Cancer	Who: _____	☐ Kidney Problems	Who: _____
☐ Death under age 50	Who: _____	☐ Seizures	Who: _____
☐ Depression	Who: _____	☐ Sickel Cell Anemia	Who: _____
☐ Diabetes	Who: _____	☐ Stroke	Who: _____
☐ Hearth Problems	Who: _____	☐ Other Mental Illness	Who: _____

Primary Insurance Information

Insurance Company		Policy ID #		Group Plan #	
Name of Policy Holder		Relationship to Student			

Secondary Insurance Information *(If applicable)*

Insurance Company		Policy ID #		Group Plan #	
Name of Policy Holder		Relationship to Student			

Student Full Name: _____ Date: _____

HONOR CARES SCHOOL BASED HEALTH CENTER DISCOUNT PROGRAM APPLICATION

All information is confidential and used for internal purposes only

At Honor Community Health School Based Health Centers, we provide services to every student, regardless of their insurance status, household income, legal status, or their ability to pay. We also offer a discount program based on the student's income, making our health care service affordable. Because the discount program is based on only the student's income, they are able to fill the application out themselves.
Once approved for a discount, no fee will be charged for any services rendered at the school. A discount will also be applied to all services at any Honor location, with the exception of major dental services at our Joslyn Smile Center but it will result in a small fee.

If you have any questions, please contact an Honor staff member. They would be happy to answer any questions.

Complete the following information, even if you have insurance.
***You may be eligible for a discount even if you have insurance.*

1 Household Size

Household Member	Number
Student	1

2 Household Income: *What is your income before taxes and deductions?*
If you do not have an income, write $0.

Household Member	Income	How are you paid? Check ONE
Student	$	☐Weekly ☐Monthly ☐Yearly

***If you are under 18 AND receiving services at a school-based health center site OR confidential services at any Honor center, report only your income and household size as one.*
** If you are paid every two weeks (bi-weekly), divide your income in half and report as weekly.*

By signing this for, you **AGREE** to apply for the Honor Cares Discount program and confirm that the information above is true and correct. You agree to tell Honor Community Health about any changes in your income. If you do not give true, correct, or timely information, you understand that you will lose your discount.

PRINT Name of Patient or Patient's Legal Guardian _____ Patient's Date of Birth _____

Signature of Patient or Patient's Legal Guardian _____ Today's Date _____

56057:00001:2000089188-1

OFFICE STAFF ONLY

Was proof of income provided? ☐Yes ☐No If so, does it match what patient documented above? ☐Yes ☐No ☐ N/A

Document the amount entered in Nextgen: $ _____

Signature of Employee who reviewed and entered information _____ Today's Date _____

v.02042026