



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:

- | | |
|---|---|
| <ul style="list-style-type: none"> 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/EPSTD exams for school, sports, camp and work Treatment for acute and chronic illnesses and injuries Tele-health services | <ul style="list-style-type: none"> 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. |
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Parental consent is not required for:

- | | |
|--|---|
| <ul style="list-style-type: none"> Pregnancy testing/services, birth control referrals Sexually Transmitted Infection screenings treatment/ counseling, testing HIV counseling, testing, treatment, and referrals | <ul style="list-style-type: none"> 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) |
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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.
- Assignment of Medical Benefits:
- I authorize my insurance to pay Honor Community Health for all services rendered
- I understand that if I do not assign medical benefits, I may be billed the full cost of services rendered
- I understand that I may be responsible for co-payments, co-insurance and deductibles
- 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	<div style="display: flex; justify-content: space-between;"> <div> ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Hispanic/Latino ☐ Middle Eastern/North African </div> <div> ☐ Native Hawaiian/Pacific Islander ☐ White ☐ More than one race ☐ Not listed/Choose not to disclose </div> </div>						
Ethnicity	<div style="display: flex; justify-content: space-between;"> <div> ☐ Mexican, Mexican American, Chicano/a ☐ Cuban ☐ Puerto Rican ☐ Guamanian/Chamorro ☐ Asian Indian ☐ Chinese ☐ Filipino </div> <div> ☐ Japanese ☐ Korean ☐ Vietnamese ☐ More than one ethnicity ☐ Another Hispanic, Latino/a, or Spanish Origin ☐ Another Asian ethnicity ☐ Not listed/Choose not to disclose </div> </div>						
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 <i>**If applicable</i>							
Last Name				First Name			
Date of Birth				Social Security #			
Phone Number				Preferred Language			
Address		City		State		Zip Code	
Emergency Contact Information <i>(Complete only if contact is NOT a parent/legal guardian)</i>							
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	<i>**Please include dosage and reason for taking medication</i> Medication: _____ Dose: _____ Reason: _____ Medication: _____ Dose: _____ Reason: _____		
Allergies	<i>**Please select all that applies and list where indicated</i> <div style="display: flex; justify-content: space-between;"> <div> ☐ Seasonal (dust, hay fever, etc.) ☐ Bee Stings ☐ Medication: _____ </div> <div> ☐ Food: _____ ☐ Other: _____ </div> </div>		
Please check if you (student) have any of the following			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> ☐ Anemia ☐ Cancer ☐ Fainting ☐ Heart Problems: _____ ☐ Kidney/Bladder/Urine Problem ☐ Rheumatic Fever ☐ Sinus Problems </div> <div style="width: 50%;"> ☐ Asthma ☐ Dental Problems: _____ ☐ Headaches/Migraines ☐ HIV/AIDs ☐ Liver Disease ☐ Seizures (with or w/o epilepsy) ☐ Skin Problems </div> <div style="width: 50%;"> ☐ Attention Deficit Disorder ☐ Diabetes ☐ Head Injury ☐ Hypertension (high blood pressure) ☐ Menstrual Problems: _____ ☐ Sickle Cell Trait ☐ Stomach Problems </div> <div style="width: 50%;"> ☐ Blood Disease ☐ Mental Illness ☐ Heart Murmur ☐ Jaundice ☐ Pregnancy, Due: _____ ☐ Sickle Cell Disease ☐ Venereal Disease </div> </div>			
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 ☐ Anxiety other ☐ Cancer ☐ Death under age 50 ☐ Depression ☐ Diabetes ☐ Hearth Problems	Who: _____ Who: _____ Who: _____ Who: _____ Who: _____ Who: _____ Who: _____	☐ Hypertension (high blood pressure) ☐ High Cholesterol ☐ Kidney Problems ☐ Seizures ☐ Sickle Cell Anemia ☐ Stroke ☐ Other Mental Illness	Who: _____ Who: _____ Who: _____ Who: _____ Who: _____ Who: _____ 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: _____

[illegible][illegible]

SBHC Pt Intake Form 09032026 – SharePoint: Documents/Public/Patient Forms/English

Document the amount entered in Nextgen: \$ _____

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