Harbor Beach Community Hospital-Student Health Center

Parent/Guardian Consent Form

The goal of the Student Health Center is to meet the physical, social, and emotional health needs of students. Improving health will improve their learning. Our services support family values and relationships as much as possible.

SERVICES: Harbor Beach Community Hospital's Student Health Center provides the following:

- Health education
- Group & Individual Counseling
- Help filling out insurance forms
- Referrals to other agencies
- Nursing Services
- Sports physicals, Fitness Assessments, & Wellness screenings

Services **not provided** at the Student Health Center include:

- Dispensing daily prescription medication (continue to follow the policies in your child's school handbook)
- Substance abuse counseling or intensive psychotherapy
- The Center **DOES NOT** dispense family planning devices; provide abortion services or referrals for abortion services.

PARENTAL/GUARDIAN CONSENT

If a signed consent form is on file, your child will be able to receive the services listed below. **By law and center policy, your child will not receive these services without consent to the extent permitted by law. Care in emergency situations will be provided with parental notification to follow.** Whenever a student receives services on a walk in basis (i.e. Tylenol for a headache) staff will attempt to notify parent or legal guardian by phone **or** will send a written note with the child. Emergency contacts will only be notified when parent can't be reached and medical condition warrants such (i.e. student must be picked up and /or needs physician assessment). A message will not be left on an unidentified voicemail/machine. If you have questions about the following services, please contact (Mrs. Cleland) 989-479-3261 x53445 or (Mrs. Hogue) 989-479-3261 x 53345

Check yes next to the services you would like your child to receive if needed.

Yes ☐ No ☐ Social/Emotional Health Counseling (i.e. bullying, anger/stress management, depression, friendship skills, etc.)

Yes ☐ No ☐ Nursing Services (**If Yes complete medical history**) (i.e. headache, stomach ache, injury, first aid, etc.)

Annual Wellness Screening

Yes ☐ No ☐ Nurse wellness screening Grades 5-12 (**If Yes complete medical history**)

Yes ☐ No ☐ Blood draw for Glucose and Cholesterol Grades 9 and 11 only

NOTES: The center will follow state laws that allow minors to obtain specific services. The center will make referrals for mental health, substance abuse, family planning, HIV/AIDS testing, Sexually Transmitted Diseases, and child abuse as outlined in state laws. Parent involvement in these situations is highly encouraged by staff. It is the responsibility of the student or parent/guardian to follow-up with referrals and to pay for those referral services.

- I have reviewed and understand the services offered by Harbor Beach Community Hospital's Student Health Center. I give consent for my child to receive the services indicated on this document. By signing this consent form, I certify that I am the legal guardian and legal custodian of

  Child's Name _____ **Grade** _____ **School** _____

  This consent form will be considered active until such time as I withdraw my consent in writing. I understand I may withdraw my consent for service upon written notice to my child's school at any time.
- I further authorize the Student Health Center to release information regarding treatment to other medical or mental health providers when needed for coordination of care and to school staff when needed to coordinate services at school.
- I acknowledge that I have received the Notice of Privacy Practices issued by Harbor Beach Community Hospital, which was effective April 14, 2003, and revised as of June 1, 2013. I understand that I can obtain a copy of the Student Health Center, Harbor Beach Community Hospital's Notice of Privacy Practices by going to https://docs.wixstatic.com/ugd/d9491d_e159d3c1168a41c794b4bc54f14e9aa3.pdf or requesting a paper copy from the Center.
- Parents/guardians may review materials to be used for health education before instruction and may observe the instruction. Topics for instruction may include but are not limited to drug education, tobacco prevention, nutrition, and decision-making skills. Please contact Center Staff at 989-479-3261.

_____ _____

Signature of parent/guardian **Date**

(Please turn over and complete) ⇨

Medical History Form--- To Be Completed By Parent/Guardian

If your child or family has a change in health that impacts **any** of the information on this form, please notify us at 989-479-3261 x53345. We will provide you with a new form or you can download one from the Student Health Center page at www.hbch.org.

Student Name: _____ **Gender: ____M ____F**
First Middle Last

Birthdate: _____/_____/_____ **Grade: _____** **Today's Date: ___/____/_____**

Address: _____
Street City State Zip

Race: □ White □ Asian □ Black or African American □ Native Hawaiian or Other Pacific Islander □ American Indian or Native Alaskan

Ethnicity: □ Hispanic or Latino □ Arabic or Chaldean **Name of Insurance: _____**

Primary Care Provider (PCP): _____ PCP Phone Number: _____

School: ___ HBCS ___ OLLH ___ Zion ____ Other_____ **County of Residence:** ___ Huron ___ Sanilac

Parent/Guardian Name: _____ **Phone Number (s):** _____

Parent/Guardian Name: _____ **Phone Number (s):** _____

Parent/Guardian Email: _____

Additional Student/Child Emergency Contacts

#1_____ Phone_____ relationship to student_____

#2_____ Phone_____ relationship to student_____

Child Medical History--- To Be Completed By Parent/Guardian

Please indicate if the child has any of the following:

Bee sting allergies ❒Yes ❒No	Seizures (epilepsy) ❒Yes ❒No	Stomach problems ❒Yes ❒No
Anemia ❒Yes ❒No	Diabetes ❒Yes ❒No	Asthma ❒Yes ❒No
High blood pressure ❒Yes ❒No	Sickle Cell Anemia ❒Yes ❒No	Heart problems ❒Yes ❒No
Bipolar disorder ❒Yes ❒No	Frequent urination ❒Yes ❒No	Pounding of heart ❒Yes ❒No
Fainting ❒Yes ❒No	Shortness of breath ❒Yes ❒No	Kidney disease ❒Yes ❒No
Bladder problems ❒Yes ❒No	Painful joints ❒Yes ❒No	Backaches ❒Yes ❒No
Headaches/migraines ❒Yes ❒No	Eczema/rashes ❒Yes ❒No	Nosebleeds ❒Yes ❒No
Sore throats ❒Yes ❒No	Pneumonia ❒Yes ❒No	Eating Disorder ❒Yes ❒No
Attention Deficit/Hyperactivity Disorder (ADHD) ❒Yes ❒No	Attention Deficit Disorder (ADD) ❒Yes ❒No	Mental Health i.e. depression, substance abuse, etc. ❒Yes ❒No
Other medical history:		
Does your child have a care plan for a chronic disease such as diabetes or asthma? ❒Yes ❒No **Please attach copy of plan** **If yes in an emergency does the Center have permission to use our EpiPen or nebulizer? ❒Yes ❒No		

Allergies (including food, medication, other/seasonal): _____

_____

Has the student ever been hospitalized for illness or surgery? ❒Yes ❒No If yes, for what? _____

_____

_____

Does the student take any daily medications? ❒Yes ❒No If yes, please list the medication, dose and what the medication is for: _____

_____