Parent/Guardian Consent Form

Hematite Health Clinic
319 E Division Street, Ishpeming, MI 49849
Phone: 906-204-2620 Fax: 906-204-2660
https://www.ishpemingschools.org/services/hematite_health_clinic
www.mqthealth.org

Please read and complete FRONT and BACK of this form. This form is needed for each student to be seen in the Clinic. Please use Ink

Student name (Last Name, First Name, Middle Initial):	Date of Birth:	Age:	Sex: Male☐ Female☐	Grade:
Address: City: Zip:	Student telephone:	Today's Date:		
Name of student's employer	Your estimate of student's annual income			

Race/Ethnicity (Optional):
☐Black or African American ☐White ☐Hispanic/Latino ☐American Indian/Alaskan Native ☐Arab ☐Asian ☐Native Hawaiian/Pacific Islander

Parent/Guardian (Last Name, First Name, Middle Initial):	Relationship to Student:	
Address (if different than child):	Parent E-Mail Address:	
Home phone:	Cell Phone:	Work Phone:
Name of Emergency Contact:	Relationship to Student:	Telephone #:

Name of Student's Physician/Clinic:	Date of last annual exam (Well Child):
Name of Student's Dentist/Clinic:	Date of last exam:

Insurance:
☐Medicaid ☐Blue Cross/Blue Shield ☐MI Child ☐TRICARE ☐Other:________________________________ ☐No insurance

Policy Holder Name (Last Name, First Name, Middle Initial):	Date of Birth:	Relationship to Student:
Address: City: State: Zip:		
Policy ID #:	Group #:	

I have been fully informed and I give my consent to the following:

- The Ishpeming Public Schools may release information to the Hematite Health Clinic for the purpose of receiving treatment and the Hematite Health Clinic may release information to the Ishpeming Public Schools for the purpose of educational case management.
- The above named student may receive all services listed on the back of this form at the Hematite Health Clinic. If I am requesting any changes to this consent, I will submit the changes in writing to the Clinic.
- Both the Hematite Health Clinic and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- Completion of a risk assessment by the above named student.
- This consent form will remain active and on file at the Hematite Health Clinic while my student is enrolled in the Ishpeming Area School District unless rescinded by me in writing.
- The Marquette County Health Department to bill my health insurance carrier for services provided to my child.
- My child's height, weight and body mass index will be entered into the Michigan Care Improvement Registry (MCIR) module. Use of this module is optional for your child and you may choose to decline this service.
- The Hematite Health Clinic may obtain a copy of the above named student's/patient's immunization record from the student's/patient's school office, and/or their primary care provider's office.

I understand that the Hematite Health Clinic is in compliance with all HIPAA laws and regulations.
The Privacy Notice is available at the clinic or online at: https://www.ishpemingschools.org/services/hematite_health_clinic
I understand that I have the right to refuse to sign this consent form; however, my child will not be able to be seen at the clinic.

Signature of Parent/Guardian: X____

Printed name: ________________________________ Date:______________

STUDENT MEDICAL HISTORY:

Taking daily medication(s) □Yes □No ***Name of medication(s) and Dosage *Condition for medication(s)	Food Allergies/Sensitivities: (list below) □Yes □No
Medication Allergies: (list below)	Surgeries (type:________________) □Yes □No Overnight Hospitalizations (why) □Yes □No
Asthma □Yes □No	Heart problems □Yes □No
Diabetes (high blood sugar) □Yes □No	Bladder problems □Yes □No
Seizure (epilepsy) □Yes □No	Cancer □Yes □No
Eczema/Rashes □Yes □No	Headaches/Migraines □Yes □No
Stomach Problems □Yes □No	Anemia (low iron/blood count) □Yes □No
ADD / ADHD □Yes □No	Thyroid Disease □Yes □No
Hypertension (high blood pressure) □Yes □No	Frequent Sore Throats □Yes □No
Sickle cell (trait or disease) □Yes □No	Nosebleeds □Yes □No
Fainting □Yes □No	Pounding of Heart □Yes □No
Kidney Disease □Yes □No	Shortness of Breath □Yes □No
Backaches □Yes □No	Frequent Urination □Yes □No
Painful Joints □Yes □No	Pneumonia □Yes □No
*Other health Problems:	

FAMILY MEDICAL HISTORY:

Please check below if any of your child's relatives (mother, father, sister, brother, aunt, uncle, grandparents) have had any of the Following illnesses and note who had them.

□Heart Problems	□Cancer
□High Cholesterol	□Diabetes (high blood sugar)
□High Blood Pressure	□Stroke
□Asthma/Emphysema/Bronchitis	□Seizures
□Death under age 50 (cause:________)	□Kidney or Thyroid Disease
□Sickle Cell Anemia/Blood problems	□Other

QUESTIONS TO DETERMINE NEED FOR CHOLESTEROL SCREENING:

Do the Parents or Grandparents of the child have a history of the following *before the age of 65?*	**Have Parents or Grandparents of this child undergone any of the following *before the age of 55?***
Heart Disease □Yes □No □Unknown	Angioplasty/Stenting □Yes □No □Unknown (unblocking of heart artery)
Heart Attack □Yes □No □Unknown	Coronary Artery Bypass □Yes □No □Unknown
Stroke □Yes □No □Unknown	Endarterectomy □Yes □No □Unknown (surgical removal of blockage from artery)
Chest Pain □Yes □No □Unknown Sudden Cardiac Death □Yes □No □Unknown	If known, does either parent have a blood cholesterol level of 240mg/dl or higher □Yes □No □Unknown

Does your child have any of these risk factors? (circle each) High Blood Pressure Smoking Diabetes Physical inactivity Obesity

Services provided at the Hematite Health Clinic:

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
• Physical exams for school, sports, and camp • Treatment for acute & chronic illness & injuries • Vision/hearing screenings and follow-up • Oral/dental screening and follow-up • Immunizations • Basic laboratory services & tests • Administration of medication • Individual, group, family, and community education • Referrals for specialty services	• Gynecological services • Pregnancy testing and referrals • Sexually transmitted disease screenings, treatment, and counseling • HIV screening and referrals • Physical/sexual abuse counseling and referrals • Crisis intervention • Substance abuse education, counseling, and referrals • Mental health assessment, counseling, and referrals

NO birth control pills or devices are dispensed/prescribed **NO abortion counseling, referrals, or services are provided**