



Parent/Guardian Consent Form

Hematite Health Clinic

319 E Division Street, Ishpeming, MI 49849

Phone: 906-204-2620 Fax: 906-204-2660

www.ishpemingschools.org/health-center

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 <input type="checkbox"/> Female <input type="checkbox"/>	Grade:
Address: _____ City: _____ Zip: _____		Student telephone: _____		Today's Date: _____	
Name of student's employer			Your estimate of student's annual income		
Race/Ethnicity (Optional): <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Arab <input type="checkbox"/> Asian <input type="checkbox"/> 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: <input type="checkbox"/> Medicaid <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> MI Child <input type="checkbox"/> TRICARE <input type="checkbox"/> Other: _____ <input type="checkbox"/> 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: www.mqthealth.org or www.ishpemingschools.org/health-center

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

<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Cancer
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Diabetes (high blood sugar)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	<input type="checkbox"/> Seizures
<input type="checkbox"/> Death under age 50 (cause: _____)	<input type="checkbox"/> Kidney or Thyroid Disease
<input type="checkbox"/> Sickle Cell Anemia/Blood problems	<input type="checkbox"/> 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? Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Heart Attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Chest Pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Sudden Cardiac Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Have Parents or Grandparents of this child undergone any of the following before the age of 55? Angioplasty/Stenting <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (unblocking of heart artery) Coronary Artery Bypass <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Endarterectomy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (surgical removal of blockage from artery) If known, does either parent have a blood cholesterol level of 240mg/dl or higher <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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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: <ul style="list-style-type: none"> 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 	Current Michigan Law allows for confidential services to mature minors in these areas: <ul style="list-style-type: none"> 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
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NO birth control pills or devices are dispensed/prescribed

NO abortion counseling, referrals, or services are provided