HEALTH DEPARTMENT of Northwest Michigan

Consent to School Health Services

Public Schools of Petoskey

Student Name: _____ Birth Date _____/_____/_____
Last First Middle Initial

Address: _____ Phone_____
City State Zip Code

Gender: ☐ Male ☐ Female ☐ Other ☐ Decline
Race: ☐ White/Caucasian ☐ Black/African American ☐ Native American ☐ Asian ☐ Other ☐ Multiple ☐ Decline
Ethnicity: ☐ Non-Arabic/Non-Hispanic ☐ Hispanic ☐ Arabic ☐ Decline

Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor child for services at the school-based health center. Students without a signed parent/guardian consent will not be seen, except for a student's first visit to the school-based health center, when staff will call the parent/guardian before providing any services, for a one-time-only verbal consent. The only other exceptions, according to Michigan Law are: emergencies threatening life or limb; pregnancy testing, substance abuse services, family planning counseling services, HIV counseling and testing, sexually transmitted infection treatment, and for minors 14 years of age or older: mental health services. People who are age 18 or older, legally emancipated, legally married, under court order, in the presence of a law officer when the parent cannot be promptly located, and/ or members of the US Armed Forces provide consent for services themselves.

Services not provided include prescribing medications, dispensing birth control, provision of abortion counseling or referrals, and dispensing of medications other than those covered under standing orders. Family planning drugs and/or devices *will not* be prescribed, dispensed, or distributed and no abortion counseling, referrals or services will be provided.

By signing this form I certify that I am the legal guardian and legal custodian of _____.
Student's name

Consent for Services

School-Based Nursing Program services include: school nursing assessment and care, minor injury treatment, over the counter medication administration, coordination of chronic disease management in partnership with the school and primary care provider, immunization assessment, referrals to establish primary care and oral health care, and nursing assessment and education of risk behaviors.

- I have reviewed and understand the services offered by the School-Based Nursing Program.
- For Parents/Guardians - I give consent for my child to receive the services described above until age 18.
- I understand it is not necessary to renew my consent yearly. I further authorize the School-Based Nursing Program to release information regarding treatment to the following: School-Based Nursing Program staff and its subcontractors, and other health care providers, including the primary care provider, when needed to coordinate care; school staff when needed to coordinate services at school and third party payers when needed for payment of services. I understand I may withdraw my consent for services at any time upon written notice.
- I understand the School-Based Nursing Program staff may access school records for the purpose of coordinating services.
- I received a copy of the Health Department's Notice of Privacy Practices brochure.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent if a healthcare professional receives a cut or exposure to my child's blood or body fluids.

Signature of Parent/Guardian/Student 18 years and older _____ Date_____

Over →

STUDENT AND FAMILY HISTORY FORM

Allergy (Medicine, food, environment)	Reaction/Severity

Medication/Prescription/Vitamins	Dose	Frequency	Route	Who prescribed this medication?	Reason

Student's Medical History

The following information will aid the School Nurse in making an accurate assessment of your child in case of illness or emergency. Please check the appropriate space if your child has ever had any of the following:

- ☐ Measles
- ☐ Mumps
- ☐ Anemia
- ☐ Birth Defects
- ☐ Diabetes
- ☐ Chicken Pox
- ☐ Rheumatic Fever
- ☐ Asthma
- ☐ Sleep Problems
- ☐ Scarlet Fever
- ☐ Seizures
- ☐ Unexplained Weight Loss
- ☐ Unexplained Tiredness
- ☐ Persistent Cough
- ☐ Unexplained Weight Gain
- ☐ Leukemia
- ☐ Stomach or Bowel Problems
- ☐ Exposed to Tuberculosis
- ☐ Shortness of Breath
- ☐ Head, Eyes, Ears, Throat Problems
- ☐ Blood Transfusions
- ☐ Anaphylactic Episodes
- ☐ Chest Pain
- ☐ Joint or Muscle Pain or Stiffness

If you answered yes to any of the above, please explain: _____

Student's Doctor: _____ Phone # _____

Student's Dentist: _____ Phone # _____

- ❖ Any Surgeries (reason/date): _____
- ❖ Any Hospitalizations (reason / date): _____
- ❖ Any serious injuries or illnesses (describe): _____

Family Medical History

Please check the appropriate space if any of the child's blood relatives (mother, father, brother, sister) has any of the following conditions:

- ☐ HIV/AIDS
- ☐ Alcohol/Drug Addiction
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Asthma
- ☐ Birth Defects
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ COPD/Emphysema/Bronchitis
- ☐ Diabetes
- ☐ Epilepsy/Seizures
- ☐ Heart Attack/Stroke
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney Disease
- ☐ Liver Disease/Hepatitis
- ☐ Mental Illness
- ☐ Osteoporosis
- ☐ Sickle Cell
- ☐ Thyroid Disorder
- ☐ Tuberculosis/TB
- ☐ Other: _____

Other:

Do you have concerns about your child's health? ☐ Yes ☐ No If "yes", explain _____

Is your child exposed to second-hand smoke? ☐ Yes ☐ No If "yes", explain _____

Does your child smoke and/or use tobacco products? ☐ Yes ☐ No If "yes", explain _____

Does your child drink alcohol? ☐ Yes ☐ No If "yes", explain _____

Is there anything else you would like us to know about your child? _____

_____

_____