MTMS HEALTH CLINIC

Located Inside
MACKINAW TRAIL MIDDLE SCHOOL
8401 S MACKINAW TRAIL
CADILLAC, MI 49601
PHONE: 231-876-5638

PARENT/GUARDIAN/CLIENT CONSENT FORM

(Please read and complete entire form)

Student Name	Date of Birth	School	
Gender	Grade	Race ☐Caucasian/White ☐Black/African American ☐Asian ☐Native Hawaiian/Pac Islander ☐multi-Racial Ethnicity ☐Arab ☐Hispanic ☐Non-Arabic/ Hispanic	
Address	City	Zip Code	Parent Phone #
Parent/ Guardian	Relationship to Student	Parent Work Phone #	
Emergency Contact	Relationship to Student	Phone #	

SERVICES THAT MAY BE PROVIDED AT THE SCHOOL CLINIC

- Sick Care/ Minor Illness
- Treatment for Acute & Chronic Illness & Injuries
- Over-the-Counter Medications
- Immunizations
- Education/ Support Programs for Nutrition/ Fitness, etc.
- Referrals for Specialty Services
- COVID-19 Rapid Antigen Testing with additional parental consent
- Lab testing for influenza and blood glucose

- I give my consent for the above-named student to receive all services as indicated in this document.
  - ☐ If you do **NOT** want your child to be given any over-the-counter medications (i.e. Tylenol)
  - ☐ If you do **NOT** want your child to receive immunizations, check this box. Immunizations will not be given without specific written or verbal consent of the parent/guardian. Visit Michigan VIS for the most current Vaccine Information Statements (VIS).
- By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above.
- I understand that it is not necessary to renew my consent yearly, but it is necessary to have updated address, phone, insurance, and my child's current health information. I further authorize the School Clinic to release information regarding treatment to the following: Clinic Staff and its' subcontractors, school staff only with a separate signed release of information (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 prior written notice.
- I authorize both the School Clinic and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care.
- I understand that my child may have the opportunity to participate in educational programs related to health and wellness topics and have the opportunity to give feedback on services and programs through surveys or focus groups.
- I understand that testing for bloodborne diseases, including HIV/ AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I understand that immunizations are provided with charges based on the client's income, and I understand that no one will be denied services regardless of ability to pay.
- I understand that my privacy and health information will be handled in a confidential manner as required by the Health Information and Privacy Act (HIPAA) as set forth by DHD #10 (see attached notice).
- I understand that if face-to-face services are not available, telehealth may be an appropriate alternative. All existing laws that apply to face-to-face services also apply to telehealth.
- I understand reasonable and appropriate efforts have been made to eliminate any confidential risks associated with telehealth.
- I understand telehealth can include consultation, treatment, transfer of medical/mental health data, emails, telephone conversations and/or education using interactive audio, video, or data communications.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE**: _____

RETURN TO: The School Clinic or School Office

STUDENT AND FAMILY HISTORY FORM

ALLERGIES (MEDICATION, FOOD, ENVIRONMENTAL)			REACTION/SEVERITY		
MEDICATION/PRESCRIPTIONS/VITAMINS	**DOSE**	**FREQUENCY**	**ROUTE**	**PRESCRIBED BY**	**REASON**

STUDENT 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 box if your child has had any of the following.

☐YES ☐NO MEASLES
☐YES ☐NO MUMPS
☐YES ☐NO ANEMIA
☐YES ☐NO BIRTH DEFECT(S)
☐YES ☐NO DIABETES
☐YES ☐NO CHICKEN POX
☐YES ☐NO RHEUMATIC FEVER
☐YES ☐NO ASTHMA
☐YES ☐NO SLEEP PROBLEMS
☐YES ☐NO HEAD/EYES/EARS/THROAT PROBLEMS
☐YES ☐NO BLOOD TRANSFUSIONS
☐YES ☐NO ANAPHYLACTIC EPISODES
☐YES ☐NO CHEST PAIN
☐YES ☐NO JOINT OR MUSCLE PAIN/STIFFNESS
☐YES ☐NO SCARLET FEVER
☐YES ☐NO SEIZURES
☐YES ☐NO UNEXPLAINED WEIGHT LOSS
☐YES ☐NO UNEXPLAINED TIREDNESS
☐YES ☐NO PERSISTENT COUGH
☐YES ☐NO UNEXPLAINED WEIGHT GAIN
☐YES ☐NO LEUKEMIA
☐YES ☐NO STOMACH/BOWEL PROBLEMS
☐YES ☐NO EXPOSED TO TUBERCULOSIS

If you checked any boxes above, please explain:

_____

_____

STUDENT'S DOCTOR _____ **PHONE NUMBER** _____
STUDENT'S DENTIST _____ **PHONE NUMBER** _____
ANY SURGERIES? (TYPE/REASON, DATE?) _____
ANY HOSPITALIZATIONS? (TYPE/REASON, DATE?) _____
ANY SERIOUS INJURIES OR ILLNESSES? (EXPLAIN) _____

RESOURCE ASSISTANCE

WOULD YOU LIKE INFORMATION FROM OUR STAFF REGARDING THE FOLLOWING?

-OPTIONS FOR HEALTH INSURANCE? ☐YES ☐NO

-FINDING A HEALTH CARE PROVIDER? ☐YES ☐NO (doctor or nurse practitioner)

-FINDING A DENTIST? ☐YES ☐NO

WOULD YOU LIKE MORE INFORMATION REGARDING MENTAL HEALTH SERVICES FOR YOUR CHILD? ☐YES ☐NO

ARE YOU CONCERNED ABOUT YOUR INCOME MEETING THE BASIC NEEDS OF YOUR FAMILY? ☐YES ☐NO

Please circle concerns:
☐FOOD ☐CLOTHING ☐HOUSING
☐TRANSPORTATION TO MEDICAL OR SCHOOL APPTS
☐HEAT/WATER BILLS

IF YOU ANSWERED YES TO ANY OF THE ABOVE, A MEMBER OF OUR STAFF MAY CONTACT YOU.

IS THERE ANYTHING ELSE YOU WOULD LIKE US TO KNOW ABOUT YOUR CHILD? _____

_____

_____