



PARENT/LEGAL GUARDIAN & CLIENT CONSENT FORM


(Please read and complete front & back)

Student's Information					
Student/Client Last Name	First	Birth Date	Male <input type="checkbox"/>	Grade	School
Street Address			Female <input type="checkbox"/>	Student's Cell Phone #	
City		Zip Code			
Race	<input type="checkbox"/> American Indian or Alaskan Native	<input type="checkbox"/> Asian or other Pacific Islander	<input type="checkbox"/> Black or African American		
	<input type="checkbox"/> White or Caucasian	<input type="checkbox"/> Other _____			
Ethnicity	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Arabic	<input type="checkbox"/> Non-Hispanic/Non Arabic		
Name of Student's Physician/Clinic			Telephone #		
Name of Student's Dentist			Telephone #		
Parent/ Legal Guardian Information or Emergency Contact if 18 yrs or older					
Last Name		First Name		Relationship To Student	
Street Address (if same as above write "same")		City	Zip Code		
Home Phone #		Cell Phone #		Work Phone #	
Insurance Information					
<input type="checkbox"/> MI Child – Type of MI Child:			<input type="checkbox"/> This is the student's: Primary Insurance		
<input type="checkbox"/> Medicaid - Name of Plan:			<input type="checkbox"/> Secondary Insurance		
Medicaid I.D. #					
<input type="checkbox"/> Blue Cross/Blue Shield		<input type="checkbox"/> HAP	<input type="checkbox"/> AETNA	<input type="checkbox"/> This is the student's: Primary Insurance	
<input type="checkbox"/> Blue Care Network		<input type="checkbox"/> Health Plus	<input type="checkbox"/> Priority Health	<input type="checkbox"/> Secondary Insurance	
<input type="checkbox"/> Other Commercial Insurance		Name of Plan: _____			
Policy Holder Name	Policy Holder's Birth Date	Relationship To Student	ID # or Contract/Policy #		
Company Name:		Employer's Address	Group #:		
<input type="checkbox"/> Emergency Medicaid Only		<input type="checkbox"/> No Insurance	<input type="checkbox"/> I would like help applying for MI Child/Healthy Kids Insurance		

The Waterford Teen Health Center is a school-based health center, managed by Oakland Primary Care Services, Inc., located within the Waterford School District's Cray Campus.

I give my consent for the above named student or myself to receive services (listed on the back of this form) at the Waterford Teen Health Center. By signing this consent form, I confirm that I am the custodial parent and/or legal guardian of the student named above. I understand that I may withdraw my consent for services upon written notice to the Health Center at any time. I authorize the Health Center to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the Health Center and my child's primary care physician to exchange health care information for the purpose of continuity and coordination of care. I give the Health Center authorization to obtain a copy of the above named student's immunization record from the school's office, primary care provider's office, or the Oakland County Health Department. I also give the Health Center authorization to refer to community agencies as appropriate.

I acknowledge receiving a copy of the Waterford Teen Health Center Notice of Privacy Practices (HIPAA) brochure.

 **SIGNATURE OF PARENT/GUARDIAN:** _____ **DATE:** _____
OR CLIENT IF 18 YEARS OLD

(Turn form over and complete other side)



Waterford Teen Health Center

501 N. Cass Lake Rd., Rm 213

Waterford, Michigan 48328

Phone (248) 674-4876 Fax (248) 682-1089



STUDENT MEDICAL HISTORY:

Please check Yes or No.

Name: _____

DOB: _____

Allergies to Bee sting <input type="checkbox"/> Yes <input type="checkbox"/> No	Allergies to Medication or Food <input type="checkbox"/> Yes <input type="checkbox"/> No	Seizure (epilepsy) <input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath/Trouble breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
type: _____		Sickle cell (trait or disease) <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies, i.e. hay fever, dust, pollen <input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia (low iron/blood count) <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision Problems / wears glasses or contacts <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety/Depression or other Mental Illness <input type="checkbox"/> Yes <input type="checkbox"/> No		Other health problems: _____	
Asthma or chronic cough <input type="checkbox"/> Yes <input type="checkbox"/> No		Overnight Hospital Stay <input type="checkbox"/> Yes <input type="checkbox"/> No	Reason: _____
Attention Deficit Disorder (ADD / ADHD) <input type="checkbox"/> Yes <input type="checkbox"/> No		Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	type: _____
Backaches <input type="checkbox"/> Yes <input type="checkbox"/> No		Taking daily medications, inhalers, vitamins, etc * <input type="checkbox"/> Yes <input type="checkbox"/> No	
Diabetes (high blood sugar) <input type="checkbox"/> Yes <input type="checkbox"/> No		*Name of medication(s) and reason for taking it: _____	
Eczema/Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No		_____	
Fainting <input type="checkbox"/> Yes <input type="checkbox"/> No		_____	
Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No			
Heart Murmur or Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No			
Hypertension (high blood pressure) <input type="checkbox"/> Yes <input type="checkbox"/> No			
Kidney or Bladder/Urine problems <input type="checkbox"/> Yes <input type="checkbox"/> No		My teen/I had their last physical _____ Month/Year	
Menstrual Problems (heavy, missed or irregular periods) <input type="checkbox"/> Yes <input type="checkbox"/> No			

FAMILY MEDICAL HISTORY:

Please check below if any of your child's relatives i.e., mother, father, sister, brother, aunt, uncle, grandparents) have had any of the following illnesses and note what relative had them.

<input type="checkbox"/> Alcoholism/ Drug Dependence	<input type="checkbox"/> Heart Problems
<input type="checkbox"/> Anxiety/Depression/ or other Mental Illness	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Asthma/Emphysema/Bronchitis	<input type="checkbox"/> Kidney Problems
<input type="checkbox"/> Cancer	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cholesterol	<input type="checkbox"/> Sickle Cell Anemia/or other problems of the Blood
<input type="checkbox"/> Death under age 50 / Sudden Cardiac Death (cause: _____)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes (high blood sugar)	<input type="checkbox"/> Other

SERVICES PROVIDED at Waterford Teen Health Center:

- Physical exams for school, sports, and camp.
- Treatment for acute & chronic, illness & injuries
- Vision/hearing screenings 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 infection screenings, treatment, and counseling
- *HIV screening and referrals
- *Crisis Intervention
- *Substance abuse education, counseling and referrals
- *Mental health and psycho-social assessment, counseling, and referrals

(*) Current Michigan Law allows for confidential services to minors in these areas.

SERVICES NOT PROVIDED

No birth control pills or devices are dispensed or prescribed
No abortion counseling, referrals or services provided

RETURN TO:

Waterford Teen Health Center 501 N. Cass Lake Rd., Rm 213 Waterford, Michigan 48328