PARENTAL CONSENT AND HEALTH HISTORY FORM

Current School: _____
Student's Name: _____ ☐ Female ☐ Male
Address: _____ City: _____ Zip Code: _____
Home Phone: _____ Birthdate: _____ Social Security #: _____
Email Address: _____ Grade: _____ Homeroom #: _____

Parent/Guardian Information

Mother/Guardian:	DOB:	Home Phone:	Cell:
Father/Guardian:	DOB:	Home Phone:	Cell:

Parent/Guardian Address:	City:	State:	Zip:

Emergency Contact:	Relationship:	Phone #:

FQHC-Required Demographic Information

It is the policy of NMHSI to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability.

Race: ☐ White ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Pacific Islander ☐ Other: _____

☐Native American/ Alaska Native – Tribal Member: ☐ Yes ☐ No Descendent: ☐ Yes ☐No

Name of Tribe: _____

Ethnicity:	☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Other: _____	Preferred Language:

Health Insurance Information

Do you currently have health insurance? ☐Uninsured ☐Medicaid ☐Private
* If no, and you or your child needs assistance applying for Medicaid or our Sliding Fee Scale, our CHW can help you!

Policyholder's Name: _____ DOB: _____

Insurance Carrier: _____ Policyholder's Employer: _____

Policy #: _____ Group #: _____

Sliding Fee Scale

Federal Regulations require that we report the *combined total* of all household members' income for those seeking care at NMHSI. We ask your cooperation in indicating the following: Total Number in Household_____ Your yearly combined household income is in which broad category below?

The yearly combined household income?	☐0-$11,490	☐$23,266-$35,325	☐$47,386-$59,446	☐$79,260 +
	☐$11,490-$23,265	☐$35,326-$47,385	☐$59,447-$79,259	

Even if you have insurance, you may qualify for NMHSI's sliding fee scale, which offers discounted fees for services.
Do you want to apply to see your qualifications? ☐Yes ☐No

Student's Health History

Student Name: _____ DOB: _____

Student Medical History: Have you had any of the following? If yes, check all that apply.		
☐Anemia	☐Heart Problems	☐Seizures
☐Asthma	☐Hepatitis	☐Shortness of Breath
☐Bladder/Kidney Infection	☐High Blood Pressure	☐Skin problems/Acne
☐Cancer	☐Mental Illness/Depression	☐Sports Injuries/Broken Bones
☐Chicken Pox	☐ Mumps	☐Strep/Tonsillitis
☐Diabetes	☐Pneumonia	☐Thyroid Problems
☐Dizziness	☐Scarlet Fever	☐Tuberculosis
☐Headaches/Migraines	☐Scoliosis	☐Ulcers/Digestive Problems
☐Surgeries/Dates:		
☐ Allergies/Reactions:		

Family Medical History: Has any member of your family (mother, father, siblings, aunt, uncles, grandparents) ever had any of the following? If yes, check all that apply.		
☐Anemia	☐Heart Problems	☐Seizures
☐Asthma	☐Hepatitis	☐Shortness of Breath
☐Bladder/Kidney Infection	☐High Blood Pressure	☐Skin problems/Acne
☐Cancer	☐Mental Illness/Depression	☐Sports Injuries/Broken Bones
☐Chicken Pox	☐ Mumps	☐Strep/Tonsillitis
☐Diabetes	☐Pneumonia	☐Thyroid Problems
☐Dizziness	☐Scarlet Fever	☐Tuberculosis
☐Headaches/Migraines	☐Scoliosis	☐Ulcers/Digestive Problems
☐Surgeries/Dates:		
☐ Allergies/Reactions:		

Consent for Services

Manistee Area Public Schools (MAPS) Care Connect School Based Health Center include ***mental health services**. ***Mental Health Services** will be consisted of the following: treatment, assessment, and individual counseling. In addition to ***mental health services** MAPS CareConnect will also provide a Community Health Worker (CHW). The CHW will act as a community resource connector offering programs to assist those in need. This may include, Medicaid Enrollment.

- I have reviewed and understand the services offered by MAPS CareConnect School Based Health. I give consent for my child to receive ***mental health services** described above until the age of 18.
- I understand I may withdraw my consent at any time with written notice and I understand it is my responsibility to be sure that MAPS CareConnect School Base Health Center has received my withdrawal of consent.
- I understand MAPS CareConnect School Base Health Staff will release information regarding treatment to the following: school staff and its subcontractors, other healthcare providers, Community Health Worker services, when needed to coordinate care.
- I understand that MAPS CareConnect School Base Health Center participates in and recognizes the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).
- I understand that MAPS CareConnect School Base Health Center Staff will have access to view records, including PowerSchool system. Access to this information includes demographic data, class schedules and attendance records for my child to coordinate appointments and absences related to School Based Health Services. Staff will follow all FERPA and HIPAA laws related to such information.
- I understand that a requested Parental Consent form may be necessary to update my child's information for our records.

By signing this consent, I confirm I am the parent or legal guardian of the above listed student and authorize to give this consent.

_____ _____

Signature of Parent/Guardian of patient (or patient age 18 years and older) Date

* Note: In accordance with Michigan legal requirements, parental consent is **NOT** required for outpatient mental health services for individuals age 14 and older. Mental Health Code, MCL 330.1707