Northwest Michigan Health Services, Inc
School Based Health Center (SBHC) Intake Form

Services Provided

- Physical exams for school, sports & camp
- Treatment for acute & chronic illness & injuries
- Immunizations
- Basic laboratory services & tests
- STD and Screening Checks
- Referrals for specialty services
- Substance use counseling & education
- Mental health counseling & referrals
- Individual or group community education
- Crisis Intervention

Services Not Provided:

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

Michigan law requires that some confidential services are available to minors without the consent or knowledge of a parent/guardian. Confidential services include advice, testing and/or treatment for mental health, drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services.

General Information

Current School:_____ Grade: _____ Homeroom #: _____

Student's Name: _____ ☐ Female ☐ Male

Student Address: _____ City: _____ Zip Code: _____

Student Phone: _____ Birthdate: _____ Email Address: _____

What is the best way to reach the **Parent**: ☐ Cell phone ☐ Home Phone ☐ Text **Student:** ☐ Cell phone ☐ Home Phone ☐ Text

Can we text appointment reminders to: **Parent:** ☐ Yes ☐ No **Student:** ☐ Yes ☐ No

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

Does the student 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: _____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: $_____

Even if the student has insurance, the student may qualify for NMHSI's sliding fee scale, which offers discounted fees for services.

Do you want to apply for our sliding fee scale? ☐Yes ☐No

Student Name: _____ DOB: _____

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

Surgeries/Dates:

Allergies/Reactions:

List all medications / vitamins you are taking:

Student Social History

Has the student ever had drug/alcohol abuse? ☐ No ☐ Yes **If yes:** ☐ current problem ☐ receiving treatment ☐ recovering	Does the student feel safe at home? ☐ No ☐ Yes
Does the student use any marijuana products? ☐ No ☐ Yes **If yes:** ☐ Smoke ☐ Vape ☐ Edibles	Does the student use tobacco products? ☐ No ☐ Yes **If yes:** _____day X _____ yrs ☐ cigarettes ☐ vape ☐ chew

What does the student drink throughout the day: ☐ Pop ☐ Diet Pop ☐ Coffee/Tea ☐ Juice ☐ Water ☐ Energy Drinks ☐ Alcohol

Family Medical History: Any member of the student's family (mother, father, siblings, aunt, uncles, grandparents) ever had any of the following? If yes, check all that apply.					
☐Anemia	☐Heart Problems	☐Seizures	☐High Blood Pressure	☐Cancer	☐Strep/Tonsillitis
☐Asthma	☐Hepatitis	☐Skin problems/Acne	☐Diabetes	☐Pneumonia	☐Thyroid Problems
☐Headaches/Migraines	☐Mental Illness/Depression	☐Scoliosis	☐Bladder/Kidney Infection	☐Scarlet Fever	☐Tuberculosis
☐Ulcers/Digestive Problems					

Consent for Services

NMHSI School Based Health Center includes **Medical, Mental Health, Referral to Community Resource Care.** ***Mental Health Services** will consist of the following: treatment, assessment, and individual counseling. In addition to ***Mental Health Services** NMHSI School Based Health Center 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 NMHSI School Based Health Center. I give consent for my child to receive **Medical, *Mental Health, Referral for Community Resource Services** described above until the age of 18. **I understand that I have the option to opt out from any of the services that are provided (I would like to opt out of _____ services at this time.)**

I understand that I will be contacted before services are provided, unless an emergency or confidential service is provided.

I understand I may withdraw my consent at any time with written notice and I understand it is my responsibility to be sure that NMHSI School Base Health Center has received my withdrawal of consent.

I understand NMHSI 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 NMHSI 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 NMHSI 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/Patient age 18 and older | Print Name | Date