Sault Health Adolescent Care Center
Chippewa County Health Department
904 Marquette, Room 622
Sault Ste. Marie, MI 49783

Phone: (906)632-5690 Fax: (906)635-1325

PARENT/GUARDIAN CONSENT FORM

Please read and complete. Consent contains 4 pages

Consent is needed for each student if: one has not previously been completed OR any changes have occurred since the last form was completed.

Student Name (Last Name, First Name, Middle Initial) *	Birth Date *	Age	Sex * Male ❒ Female ❒	Grade	School

Address *	City *	Zip Code *	Student Telephone #	Today's Date

Race / Ethnicity (Optional)

❒ Black or African American ❒ White ❒ Hispanic/Latino ❒ American Indian/Alaskan Native ❒ Arab ❒ Asian ❒ Native Hawaiian/Pacific Islander

Mother/Guardian: Last Name	First Name	M.I.	Relationship to Student

Daytime Telephone #	Work Telephone #	Cellular / Pager #	Parent E-Mail Address

Father/Guardian: Last Name	First Name	M.I.	Relationship to Student

Daytime Telephone #	Work Telephone #	Cellular / Pager #	Parent E-Mail Address

Name Of Emergency Contact	Relationship	Telephone #

Name of Student's Primary Care Provider/Clinic	Telephone #

Name of Student's Dentist	Telephone #

Name of Student's Employer	Your estimate of student's annual income

Medical Insurance *

❒Medicaid ❒ Blue Cross/Blue Shield ❒ NGS Insurance ❒ MI Child ❒ TRICARE ❒ Other: ❒ No insurance

I.D./Contract # *	Policy/Group # *	Student Relationship to Policy Holder *

Policy Holder Name (Last Name, First Name, Middle Initial) *	Policy Holder Date of Birth *	**Please provide a photocopy of both sides of your insurance card.**

Address *	City *	State *	Zip Code *

Secondary Medical Insurance *

❒Medicaid ❒ Blue Cross/Blue Shield ❒ NGS Insurance ❒ MI Child ❒ TRICARE ❒ Other: ❒ No insurance

I.D./Contract # *	Policy/Group # *	Student Relationship to Policy Holder *

Policy Holder Name (Last Name, First Name, Middle Initial) *	Policy Holder Date of Birth *	**Please provide a photocopy of both sides of your insurance card.**

Address *	City *	State *	Zip Code *

I understand that treatment for general medical and behavioral health services may be obtained at my primary provider's office and that obtaining duplicate services may affect my benefits received from private, state or federal insurances or third-party provider.

I consent to all of the following:

- The Sault Area Public Schools may release information to the Sault Health Adolescent Care Center for the purpose of receiving treatment. This includes school photos for the purpose of identification.
- The date and time of appointment is disclosed to Sault Area Public Schools for the purpose of excused attendance.
- The above-named student may receive all services listed below at the Sault Health Adolescent Care Center (SHACC). If I am requesting any changes to this consent, I will submit the changes to the SHACC in writing separately.
- The completion of a risk assessment by the above-named student.
- The Sault Health Adolescent Care Center may release information regarding treatment to third party payers or others for the purpose of receiving payment for services. If required by law, separate release forms will be used at time of service.
- Both the Sault Health Adolescent Care Center and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- The Sault Health Adolescent Care Center may obtain a copy of the above-named student's/patient's immunization record from the student's/patient's school office, their primary care provider's office and/or the Michigan Care Improvement Registry (MCIR).
- This consent form will remain active and on file at the Sault Health Adolescent Care Center while my student is enrolled in the Sault Area High School, Malcolm High School, Sault Middle School or Sault Area Career Center unless rescinded by me in writing.

Services provided at the Sault Health Adolescent Care Center

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
➢ Comprehensive physical exams ➢ Treatment for acute & chronic illness & injuries ➢ Vision/hearing screenings and follow-up ➢ Immunizations including COVID-19 and influenza ➢ Basic laboratory services & tests including COVID-19, influenza, and strep ➢ Administration of medication ➢ Individual, group, and family education ➢ Referrals for specialty services ➢ Allergy injections ➢ Wart removal ➢ Concussion assessment/management ➢ Health education and wellness promotion ➢ Telehealth ➢ Substance abuse education, counseling, and referrals ➢ Mental Health assessment, counseling, and referrals	➢ Pregnancy testing and referrals ➢ Sexually transmitted infection screenings, treatment, and counseling ➢ HIV screening and referrals ➢ Physical/sexual abuse counseling and referrals ➢ Substance abuse education, counseling, and referrals ➢ Mental health assessment, counseling, and referrals

➢ ***PARENTAL CONSENT IS NOT NEEDED FOR CRISIS INTERVENTION AND EMERGENCY CARE***

LIMITATION OF SERVICES

- ***NO*** form of birth control or devices, including condoms are dispensed or prescribed
- ***NO*** abortion counseling, referrals or services are provided

By signing this consent form, I certify that I am the parent/legal guardian of the student- OR student is at least 18 years of age- named above and is registered with the school as such.

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

OR

STUDENT 18 YEARS OF AGE : _____ **DATE:** _____

We serve students enrolled in Sault Area High School, Middle School and Malcolm School, without regard to race, religion, color, national origin, creed, handicap, sex, sexual orientation, or sexual preference. Services are also provided to infants and pre-school children of students.

Sault Health Adolescent Care Center (SHACC): Patient Health History

Patient Name: _____ Date of Birth: _____

Allergies (medication, food, environmental):	Reaction:

Medications (RX, vitamins)	Dose (mg)	Frequency	Route (oral, topical)	Prescriber	Reason

Condition	Yes	No	Don't Know	Date Diagnosed	Details
Acne					
ADD/ADHD					
Anemia					
Asthma					
Autism					
Behavioral concerns					
Blood transfusion					
Breathing problems					
Bone, joint, muscle problems					
Bone marrow or organ transplant					
Cavities (multiple) or teeth problems					
Cancer:					
Chemotherapy					
Chickenpox or zoster (shingles)					
Concussion or head injury					
Depression					
Developmental delays (speech or motor)					
Diabetes (Type 1 or Type 2)					
Eating disorder:					
Eye problems:					
Frequent colds, ear infections or sore throats					
Frequent nosebleeds					
Headaches (frequent >3/week)					
Hearing problems					
Heart murmur or other heart problem					
High blood pressure					
HIV/AIDS					
HYPERthyroid/HYPOthyroid					
Kidney, ureter, or bladder problems					
Metabolic/ genetic disorders					
Overweight/obesity					
Pregnancy or miscarriage					
School problems or learning difficulties					
Seizures, convulsions or epilepsy					
Serious injury or fracture					
Sexually transmitted infections					
Sleep problems or snoring					
Tobacco, vape, alcohol, or drug use					
Other:					

Has your child ever had surgery? ☐ Yes ☐ No If yes, please describe details below.

Surgery/Procedure	Date of Surgery/Age	Details

Sault Health Adolescent Care Center (SHACC): Family History

Condition	Mom	Dad	Sibling	MGM*	MGF*	PGM*	PGF*	Other	Details
Alcohol use problems									
Alzheimer's disease									
Anemia									
Anxiety									
Asthma									
Bleeding disorder									
Blood clot: _____									
Bipolar									
Cancer (before age 55): _____									
CHF (congestive heart failure)									
COPD/emphysema									
Crohn's Disease									
Cystic fibrosis									
Developmental disability									
Depression									
Diabetes (Ty e 1 or Type 2)									
Eating disorder: _____									
Eczema									
Ectopic Pregnancy									
Endometriosis									
Fibromyalgia									
Genetic/metabolic disorder									
Heart attack (myocardial infarction)									
Heart disease (before age 55 years)									
Hepatitis or liver disease									
High blood pressure									
High cholesterol									
HIV or AIDS									
HYPERthyroidism									
HYPOthyroidism									
Kidney disease									
Lupus									
Lyme disease									
Migraine									
Musculoskeletal disorder: _____									
Obesity									
Parkinson's disease									
PCOS (poly cystic ovarian syndrome)									
Psoriasis									
Rheumatoid arthritis									
Schizophrenia									
Seizures or epilepsy									
Sickle cell anemia									
Stroke									
Sudden death (before age 50): _____									
Substance use problems: _____									
TB (tuberculosis									
Tobacco use									
Ulcerative colitis									
Urinary/bladder problems									
Vision or eye problems (glaucoma etc.)									

Maternal grandmother = **MGM **Maternal grandfather = **MGF** **Paternal grandmother = **PGM** **Paternal grandfather = **PGF**