

Health center services include: primary care; treatment for illness and injuries; physical exams for school, sports, and camp; basic laboratory services and tests; referral for specialty health services; student health assessment, education, and risk reduction programs; chronic disease management; immunizations; family planning counseling services; sexually transmitted diseases; HIV counseling and testing; medication administration; vision/hearing screenings; dental care; and individual, family and group counseling services.

The health center does not prescribe or dispense birth control methods or provide abortion counseling, services, or referrals.

Child/Adolescent Name		Birth Date	Age	Gender	Grade	School
Street Address		Mailing Address (PO Box)	City		Zip Code	Home Phone Number
Race (Optional) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> More Than One <input type="checkbox"/> Other						
Ethnicity (Optional) <input type="checkbox"/> Non-Arabic/Non-Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Arabic						
Mother Last Name		Mother First Name		Father Last Name		Father First Name
Guardian Last Name (if different than mother/father)		Guardian First Name (if different than mother/father)			Relationship To Student	
Daytime Telephone Number		Evening Telephone Number	Cell Phone/Pager		E-Mail Address	
Name of Emergency Contact (other than parent/guardian)			Relationship		Telephone Number	
Name of Student's Physician or Clinic		Physician or Clinic Telephone Number			Name of Student's Dentist	
Name of Pharmacy					Pharmacy Telephone Number	

1. Would you like information from our staff regarding:	
Options for health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a health care provider (doctor or nurse practitioner)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Finding a dentist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you or any of your family members have anything you would like to discuss with the Social Worker?	
Do you have concerns about the emotional well being of yourself/your child?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you concerned about your income meeting the basic needs of your family?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Please circle your concerns: Food Clothing Housing Paying for bills for heat and water Transportation to medical or school appointments	
<i>If you answered YES to any of the above, a member of our staff will contact you</i>	

Is there anything else you would like us to know about you?



IRONMEN HEALTH CENTER
Mancelona Family Resource Center
205 Grove St., Mancelona, MI 49659
(231) 587-9840
Fax (231) 587-9846



HORNET HEALTH CENTER
Pellston Middle/High School
172 Park St., Pellston, MI 49769
(231) 539-8550
Fax (231) 539-8616



RAMBLER WELLNESS PROGRAM
Boyne City Elementary School
930 Brockway Boyne City, MI 49712
Boyne City Middle School
1025 Boyne Ave Boyne City, MI 49712
(231) 439-8253



GAYLORD BLUE DEVIL WELLNESS CENTER
Gaylord High School
90 Livingston Blvd., Gaylord, MI 49735
(989) 732-6890
Fax (989) 705-1037

MINOR CONSENT

Confidential Services:

Under Michigan law, I understand that minors may without parental consent, receive advice, testing and/or treatment for substance abuse, family planning counseling services; sexually transmitted diseases, HIV, and mental health services, which are defined as Confidential Services.

I further understand that minors above the age of 14 years can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. I understand that the counselor treating me may notify my parent or guardian without my permission if someone is hurting me or I am hurting myself or someone else, or if I have a plan to hurt myself or someone else, or if it is seen to be in my best interest. In those cases, the counselor will try to inform me of their duty to notify my parents before informing them.

If I am seeking information or intervention about one of the confidential services, I understand that I can seek care related to these issues at the Child and Adolescent Health Center.

I have read and understand the above information and sign it freely and voluntarily.

By signing this form I agree to the following :

- **I have reviewed and understand the Confidential Services offered by the health center. I give my consent to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I further authorize the Child and Adolescent Health Center to release information regarding treatment to the following: Health Center staff, its subcontractors, and other health care providers when needed to coordinate care and school staff when needed to coordinate services. I understand I may withdraw my consent for services at any time upon written notice.**
- **I received a copy of the Health Department's *Notice of Privacy Practices* brochure.**
- **I have completed the enclosed *Student and Family Health History* form on the back side of this form.**
- **I understand there will be no charge or billing for this service.**

Consent to Photograph

I, the undersigned, authorize photographs to be taken of me/my child for the health center. I further authorize Health Department of Northwest Michigan to use any such photographs for the purpose of illustrations or publications.

(DATE)

(Printed Name and Birth Date)

(Signature)

(Witness Signature)

CLIENT AND FAMILY HISTORY FORM

Allergy (Medicine, food, environment)	Reaction/Severity

Medication/Prescription/Vitamins	Dose	Frequency	Route	Who prescribed this medication?	Reason

Last Complete Physical Exam _____ **Last Dental Exam** _____

CLIENT AND FAMILY MEDICAL HISTORY – Please check which family member has/had these conditions.

Disease/Condition	Client	Mother	Father	Sibling	Grand-parent	Other	Comment
Addiction – Type:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Birth defects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Blood/Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Death Under Age 50 - Cause:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Developmental Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eating disorders/Special diet/Pica	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine/Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genetic abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hepatitis/Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immune Suppression/HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kidney/Urinary disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurologic disorder/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Obesity BMI > 95%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Overweight BMI 85%-94%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Physical/Sexual/Verbal/Domestic Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric disorders/Depression/Suicide - Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pulmonary/TB/Asthma - Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin disorder - Specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Source of family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Unknown family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other relevant patient or family history	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

CLIENT HISTORY – Please check if your child has had/does have any of these conditions.

Condition	Date of Onset	Comment
ADD/ADHD		
Anaphylaxis		
Autism		
Back injuries		

CLIENT HISTORY (cont.)

Backaches		
Bladder conditions		
Fainting		
Food allergies - Specify		
Frequent sore throat		
Frequent urination		
Problems with head, eyes, ears, nose, or throat		
Headaches		
Hearing problems		
Heart abnormalities/Murmurs		
Hernias		
Mental Health Conditions		
Nosebleeds		
Painful joints		
Pneumonia		
Problems with childhood vaccines		
Psycho-Social problems		
Rheumatic Fever		
Seasonal Allergies		
Secondhand smoke		
Shortness of breath		
Skin conditions		
Vision problems		
Other:		
<i>Substance Use</i>		
Alcohol		
Chew/Tobacco		
Cigarettes		
Cocaine		
Marijuana		
Other:		
<i>Surgery/Hospitalizations</i>		
Adenoids removed		
Appendectomy		
Asthma Exacerbation		
Ear tubes		
Fracture		
Head injury/Concussion		
Heart Surgery		
Premature birth		
Tonsilectomy		
Trauma		
Other:		

Reviewed with client _____
Initials Date

Please return completed form to:



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The Child and Adolescent Health Program is operated by the Health Department of Northwest Michigan, with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.