CHILD AND ADOLESCENT HEALTH PROGRAM
Rambler Wellness Parent/Guardian Consent for Services

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School

Street Address	Mailing Address (PO Box)	City	Zip Code	Home Phone Number

Race (Optional) ❒ White ❒ Black ❒Asian ❒American Indian ❒ More Than One ❒ Other

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒Hispanic ❒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

HEALTH INSURANCE (Please complete all information)

❒ **None (uninsured) Please contact me about MIChild/Healthy Kids health insurance for my child.** ❒ **Yes** ❒ **No**

❒ **Medicaid/Medicaid Health Plan** **Child's Card Number** _____

❒ **Blue Cross/Blue Shield**
❒ **Blue Care Network**
❒ **Priority Health**
❒ **TriCare**
❒ **Other:**_____

Name of Policy Holder _____
Insurance Policy Number _____
Insurance Group Number _____
Birth Date of Policy Holder _____
Relationship of Policy Holder to child? _____
Does your insurance pay for immunizations? ❒ **Yes** ❒ **No**

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

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

_____

_____

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

Over, please

PARENT/GUARDIAN CONSENT

Child/Adolescent Name

Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor children for services at the health center. Students without a consent form signed by a parent/guardian on file will not be seen, except for a student's first visit to the Rambler Wellness Program, when staff will telephone parent/guardian for verbal consent on a one-time-only basis. The only other exceptions, according to Michigan law are: emergencies threatening life or limb; substance abuse services; family planning counseling services; HIV counseling and testing; sexually transmitted infection treatment; and-- for minors 14 and older—mental health services. People who are age 18 or older, legally emancipated, legally married, under court- order, in the presence of a law officer when the parent cannot be promptly located, and/or members of the US Armed Forces provide consent for services themselves.

Services not provided include prescribing medications, dispensing birth control, provision of abortion counseling or referrals, and dispensing of medications other than those covered under standing orders.

Parent/Guardian Signature needed here.

By signing this form I certify that I am the legal guardian and legal custodian of _____.
Student's name

Consent for Services

Rambler Wellness services include: mental health services (individual, family and group counseling); and medical services, including: school nursing services, including nursing assessment and care, injury treatment, medication administration, chronic disease management, basic laboratory services and tests, referral for specialty health care services; and primary care services through the use of telehealth equipment.

- I have reviewed and understand the services offered by the Rambler Wellness Program.
- For Parents/Guardians - I give consent for my child to receive the services described above until age 18.
- I understand it is not necessary to renew my consent yearly. I further authorize the Rambler Wellness Program to release information regarding treatment to the following: Rambler Wellness Program staff and its subcontractors, and other health care providers when needed to coordinate care; school staff when needed to coordinate services at school, including communicable disease response; and third-party payers when needed for payment of services. I understand I may withdraw my consent for services at any time upon written notice.
- I understand that Rambler Wellness Program staff may access school records for the purpose of coordinating services.
- I received a copy of the Health Department's Notice of Privacy Practices brochure.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to my child's blood or body fluids.
- I understand that if additional services are needed, telehealth technology may be offered to connect with Munson Healthcare Boyne Area Health Center to work together for a diagnosis and treatment plan.

_____ _____
Signature of Parent/Guardian/Client 18 years and older Date

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.

Signature _____ **Date:** _____

Next page, please

Child/Adolescent Name

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

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		

Over, please

Child/Adolescent Name

CLIENT HISTORY (cont.)

Condition	Date of Onset	Comment
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:		
Substance Use		
Alcohol		
Chew/Tobacco		
Cigarettes		
Cocaine		
Marijuana		
Other:		
Surgery/Hospitalizations		
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 your child's school to the attention of:

Sue McCloskey, School Nurse
RAMBLER WELLNESS PROGRAM
Boyne City Middle School
1025 Boyne Ave Boyne City, MI 49712
(231) 439-8253

Next page, please

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.

MUNSON HEALTHCARE
Boyne Area Health Center

A service of Charlevoix Hospital

Michael J. Harmeling, MD
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Catherine A. Wonski, MD
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MINOR CONSENT FORM

_____
Today's Date

I, _____ authorize Munson Healthcare Boyne Area Health Center to provide the following service: *Telehealth services with Rambler Wellness, a school wellness program at Boyne City Public Schools, operated by the Health Department of Northwest Michigan* to my child, _____, without my presence.

I understand that Munson Healthcare Boyne Area Health Center will not see my child without my presence unless this authorization has been signed and dated by myself and my spouse, if applicable.

Child's full name: _____

Child's date of birth _____ / _____ / _____

_____ _____
Father's Signature Mother's Signature

_____ _____
Witness Title

This authorization is in effect for one year from the date signed.