



EAST JORDAN WELLNESS CENTER
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) <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			

HEALTH INSURANCE (Please complete all information)

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

Medicaid/Medicaid HMO Child's Card Number _____

<input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> Blue Care Network <input type="checkbox"/> Priority Health <input type="checkbox"/> TriCare <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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. 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?

PARENT/GUARDIAN CONSENT

Child/Adolescent Name

Parent/Guardian Consent Policy

Parents/guardians must provide consent for their minor children for services at the East Jordan Wellness 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 East Jordan Wellness Center, when staff will telephone parent/guardian for verbal consent on a one-time-only basis. The only other exceptions, according to Michigan law are: substance abuse services; family planning counseling services; HIV counseling and testing; 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.

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

Consent for Services

East Jordan Wellness Center services include: mental health services (individual, family and group counseling); student health assessment, education and risk reduction programs; and Medicaid Outreach.

- I have reviewed and understand the services offered by the East Jordan Wellness Center.
- 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 East Jordan Wellness Center to release information regarding treatment to the following: East Jordan Wellness Center staff and its subcontractors, and other health care providers when needed to coordinate care; school staff when needed to coordinate services at school; 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 received a copy of the Health Department of Northwest Michigan's Notice of Privacy Practices brochure.

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 East Jordan Wellness Center. I further authorize the East Jordan Wellness Center to use any such photographs for the purpose of illustrations or publications.

Signature

Date:

Please return completed form to:



East Jordan Public Schools
PO Box 399, 101 Maple Street
East Jordan, MI 49727
Rebecca Litzner, LMSW
(231) 536-2204
Amber Southerton, LMSW
(231) 536-7564
Alice Thumser, School Nurse
(231) 536-2269
Fax (231) 536-3536

The East Jordan Wellness Center is operated by East Jordan Public Schools and the Health Department of Northwest Michigan, with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.

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:	<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"/>	
Mental Retardation/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		

Child/Adolescent Name

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:		
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		
Tonsillectomy		
Trauma		
Other:		

Reviewed with client _____
Initials Date

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