Department of Pediatrics
School-Based and Community Health Program (SBCHP)

PATIENT (18 and OVER) OR GUARDIAN CONSENT FORM

Name: Last First M.I. **Pronouns:** **Grade:**

Name on Insurance: Last First M.I. **Date of Birth:** **Month** / **Day** / **Year**

What is the patient's (your) gender identity?
❒ Girl/Woman ❒ Transgender Girl/Woman
❒ Boy/Man ❒ Transgender Boy/Man
❒ Genderqueer or non-binary ❒ Additional identity (fill in)________________________

What was patient's (your) sex assigned at birth?
❒ Male ❒ Intersex
❒ Female ❒ Don't know
Were you adopted? ❒

Race (Optional): ❒ Black/African American ❒ White ❒ Native Hawaiian/ Other Pacific Islander ❒ American Indian/Alaskan Native ❒ Asian ❒ More than one race

Ethnicity (Optional): ❒ Hispanic/Latino ❒ Arab/Chaldean ❒ Non-Hispanic/Latino/Arabic

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ❒ Yes ❒ No	**Parent Cell Phone** ( ) **Parent Email address:**	**Work/Alternate Phone** ( ) **Ok to leave voicemail?** ❒ Yes ❒ No	**Patient Cell Phone** ( ) **Ok to text?** ❒ Yes ❒ No
Address		**City**	**Zip Code**

Name of Emergency Contact	**Relationship to Patient**	**Telephone Number**
Medical Insurance Type:	**Member ID Number**	**Group Number**
Insurance Member Name (parent/guardian/self)	**Member Birth Date** / /	**Relationship to Patient**

IF PATIENT IS UNDER 18 Please provide the following information of the PARENT OR GUARDIAN:
Last Name: First Name: M.I. Date of Birth: / / Relationship To Patient:

PATIENT MEDICAL HISTORY: Please Check 'Yes' or 'No' for each item listed below

When was last physical?	
Any allergies to medications? If yes, please list medication and reaction:	❒Yes ❒No
Any history of severe allergic reaction or anaphylaxis?	❒Yes ❒No
Any food allergies? If yes, please list:	❒Yes ❒No
Any medications on a daily basis? If yes, please: list medication and dose:	❒Yes ❒No
Any surgeries (i.e., tonsils, hernia, appendix). If yes, please list type of surgery:	❒Yes ❒No
Any mental health history (i.e. anxiety, depression):	❒Yes ❒No

Does the patient have any of the following:	
Asthma	❒Yes ❒No
Bladder problems (bedwetting)	❒Yes ❒No
Seizure (epilepsy)	❒Yes ❒No
Anemia (low iron/blood count)	❒Yes ❒No
Diabetes	❒Yes ❒No
Hypertension (high blood pressure)	❒Yes ❒No
Concerns with weight	❒Yes ❒No
Sickle Cell Disease/Trait	❒Yes ❒No
Eczema/rashes/skin problems	❒Yes ❒No
Heart problems	❒Yes ❒No
Stomach problems	❒Yes ❒No
Headaches	❒Yes ❒No
ADD/ADHD (attention deficit disorder)	❒Yes ❒No
Fainting or concussion	❒Yes ❒No
Hay fever/Sinus problems	❒Yes ❒No
Other health problems. Please list:	❒Yes ❒No

FAMILY HISTORY: Please place a check below each family member who may have one of the diseases below. Unknown? ❒Yes

	Mental Health	**Asthma**	**Cancer**	**Diabetes**	**Heart Disease**	**High Cholesterol**	**High Blood Pressure**	**Seizures**	**Sickle Cell**	**Thyroid Disease**
Mother										
Father										
Sister										
Brother										
Grand-mother										
Grand-father										
Other:										

PLEASE TURN OVER ➔

Patient Name: ______________________________________ Date of Birth: ___________________

I consent to all of the following:

- The above named patient may receive all available medical and behavioral health services provided at your HFHS SBCHP location.
- Tele-health services, available at specific sites provide your child an opportunity to receive services by a licensed health care provider when a provider is not on site.
- The SBCHP, my child's school and my child's health care provider may exchange health care information and school records for the purpose of continuity and coordination of care.
- The SBCHP may release information regarding treatment to insurance companies or others for the purpose of receiving payment for services.
- If my child is found to need prescription medication at the time of the clinic visit, I give permission for him/her to transport the medication unsupervised from school to home.

By completing and signing this form, I am saying that I am the guardian of the student named above who is under the age of 18; or I am the patient named above and 18 or older. I also understand that if my child is currently in elementary, middle or high school, that this consent will remain valid until my child changes schools or graduates. If your child's new school is affiliated with our program, you will be asked to complete a new consent at that time. I understand that I may cancel my consent for services by giving written notice to SBCHP at any time.

I acknowledge receiving a copy of the Henry Ford Health System Notice of Privacy Practices.

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✐**SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE**

I consent for the staff of the SBCHP to obtain a copy of the above named patient's immunization record from the patient's school office, primary care provider's office, local health department and/or MCIR (Michigan Care Improvement Registry). If the records show that my child needs any immunizations, as recommended by the Center for Disease Control and the American Academy of Pediatrics, I agree that all can be given at the SBCHP location. I understand that a form explaining any shots my child needs along with specific vaccine information sheets (VIS) will be sent home prior to the vaccine being given. If I decide that I do not want a shot(s) to be given to my child then I must sign and return the form to the school within the following week.

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✐**SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE**

If the HFHS SBCHP has taken photos/videos that include my child, they may be used to promote the health center and healthy activities through various print and internet media, including the Children's Health Fund.

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✐**SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE**

If an urgent but non-emergency health care related issue comes up on a day that the medical provider is at a different location and you are unable to come to the school (due to work or transportation reasons), your signature below authorizes us to provide tele-health provider services (if available) or transport your child to receive the necessary care. Your child will be chaperoned (by school personnel, school nurse or a Henry Ford Health System employee) to the provider location (mobile medical unit or fixed health center). We will contact you prior to transportation. Once the evaluation is complete, we will notify you of our findings and whether your child is ok to return to school or needs to go home. Please note that transportation for emergency care does not require your consent. If any emergency situation arises while your child is in our care, we will first call EMS and then immediately notify you.

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✐**SIGNATURE OF PARENT/GUARDIAN/PATIENT (18 and Older) DATE**

Please complete both sides of this form and return to:
Henry Ford School-Based and Community Health Program. Thank you.