Three Rivers Health
School Linked PAWS-Community Adolescent Health Center (CAHC) and School Based E3 Program

PARENT/GUARDIAN/PATIENT (18 and OVER) CONSENT FORM

Name		Date of Birth	Male Female
Address	City		Zip Code
Parent/Guardian:		Date of Birth (parent/guardian)	
Home/Cell Phone Number	Alternate Phone Number	Email Address:	
Name of Emergency Contact	Relationship to Patient	Phone Number	
Name of Primary Care Provider (if other than PAWS/CAHC)		Phone Number	
Medical Insurance Type:	Member ID Number	Group Number	
Member Name (parent/guardian)	Member Date of Birth	Relationship to Patient	
Pharmacy Preferred to use:			

I consent to all of the following:

- The above named person may receive all services via in person office visits, telemedicine, and or virtual visits with the PAWS/CAHC Clinic and or the School Based E3 Program.
- I understand services are provided to anyone between the ages of 10-21, and their infants and young children, regardless of their ability to pay. All insurance plans are accepted, including Medicaid and Medicaid Health Plans. Insurance will be directly billed and co-pays may be collected at time of service. There is a sliding fee scale for those without insurance.
- The PAWS/CAHC and E3 Program may release information regarding treatment to third party payers or others for the purpose of receiving payment for services.
- I authorize PAWS CAHC and the E3 Program to release information regarding treatment and care to the following; PAWS CAHC and E3 Program staff, its subcontractors, and health care providers when needed to coordinate care; and relevant school staff, on a need-to-know basis, when needed to coordinate services for the health and safety needs for the student-including communicable disease response-and insurance companies when needed for payment of services.
- I authorize the exchange of information between school officials and clinic staff enabling my child to receive the best available services. *(Information might include medical, educational, and or mental health information only as necessary to ensure your child's safety and well-being on a need-to-know basis. We understand and value you and your child's privacy).*
- I understand that PAWS CAHC and E3 Program staff may access school records for the purpose of coordinating services and for overall program evaluation and may include academic, discipline, and absence data.
- The PAWS/CAHC may obtain a copy of the above named patient's immunization record from the patient's school office, primary care provider's office, State of Michigan MCIR Registry or local health department.
- The PAWS/CAHC has permission to photograph my child for the purposes of identification, for the use of displays within the health clinic, and/or use in the school or community newspaper.

By signing this consent form, I certify that I am the parent/guardian of the above named patient under the age of 18; or the patient named above if not a minor. I understand this consent is valid for the student's school career and that I may withdraw my consent for services upon written notice to the Three Rivers Health School linked PAWS/CAHC at any time. ***I acknowledge receiving a copy of the Three Rivers Health Notice of Privacy Practices.***

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

PLEASE Complete/READ Backside

STUDENT MEDICAL HISTORY: Please check YES or NO

Bee Sting Allergy	□ YES □ NO	Seizures (epilepsy)	□ YES □ NO	Psychological Disorder	□ YES □ NO
Anemia	□ YES □ NO	Stomach Problems	□ YES □ NO	Thyroid Disease	□ YES □ NO
Seasonal Allergies	□ YES □ NO	Heart Problems	□ YES □ NO	Frequent Sore throats	□ YES □ NO
Asthma	□ YES □ NO	Bladder Problems	□ YES □ NO	Nosebleeds	□ YES □ NO
Diabetes	□ YES □ NO	Cancer	□ YES □ NO	Backaches	□ YES □ NO
Eczema/rashes	□ YES □ NO	Headaches/migraines	□ YES □ NO	Frequent urination	□ YES □ NO
ADD/ADHD	□ YES □ NO	High Blood Pressure	□ YES □ NO	Kidney disease	□ YES □ NO
Sickle Cell	□ YES □ NO	Fainting	□ YES □ NO	Shortness of breath	□ YES □ NO
Pounding Heart	□ YES □ NO	Pneumonia	□ YES □ NO	Learning Disability	□ YES □ NO

Daily Medication: _____

Reason for Medication: _____

Medication Allergy: _____

Food Allergy: _____

Surgeries: _____

Hospitalizations: _____

Other Health problems: _____

FAMILY MEDICAL HISTORY: Please check below if any of your child's relatives (i.e., mother, father, sister, brother, aunt, uncle, grandparents) have had any of the following illnesses. **Please note what relative had them**.

Heart Problems □ YES □ NO (_____) Cancer □ YES □ NO (_____) Diabetes □ YES □ NO (_____)

High Blood Pressure□ YES □ NO (_____) Stroke□ YES □ NO (_____) Asthma/emphysema□ YES □ NO (_____)

Seizures □ YES □ NO (_____) Kidney Issues □ YES □ NO (_____) Sickle Cell Anemia □ YES □ NO (_____)

Death under 50 □ YES □ NO (_____) Cause (_____) Other: _____

Parental consent is required for the following services provided to students/patients under the age of 18:

MEDICAL SERVICES:

- Physical exams for school, sports, and camp
- Treatment for acute & chronic illness & injuries
- Immunizations, Hearing and Vision screenings and follow-up.
- Dental Screening and referral
- Basic laboratory services & tests
- Administration of medication(s)
- Referrals for specialty services

MENTAL/BEHAVIORAL HEALTH SERVICES:

- Assessment
- Case Management
- Education
- Individual and group
- Referrals for Psychiatric services & medication management available thru PAWS/CAHC Primary Care Services

Current Michigan Law allows for confidential services to mature minors in these areas:

- Pregnancy testing and services
- STI/HIV testing, education, treatment, and counseling
- Substance abuse use education, counseling and treatment
- Mental health counseling – minors above the age of 14 year can obtain outpatient mental health services not to exceed 12 visits over 4 months and not to include medications.

❖ ***Students may access confidential services at their request during school hours.***

LIMITATION OF SERVICES

❖ ***NO*** abortion counseling, referrals or services are provided at the School linked PAWS/CAHC

Services Provided through the PAWS/CAHC School Based E3 Program

- Mental Health Assessment
- Individual Counseling
- Evidenced Based Treatment Groups
- Cognitive Behavior Therapy

❖ Referrals for Psychiatric services & medication management available thru PAWS/CAHC Primary Care

Return to: **Your child's School Office or Three Rivers Health PAWS/Community Adolescent Health Center (CAHC)**
ATT: Kiel Lucas, BSN, RN Program Coordinator / School-linked Nurse Liaison