HENRY FORD HEALTH℠

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

Consent Form: To be completed by Parent/Guardian or Patient (age 18 or over)

Patient's Legal Name (First, Last, Middle Initial): _____

I understand and agree to the following:

- This consent form is valid until the child turns 18. At that time, they can sign their own consent form.
- I can cancel this consent by giving a written letter to the health center.
- The patient may get telehealth or virtual health care from a Henry Ford Health doctor or provider
- The health center can share the patient's health information with other health care and behavioral health providers.
- The health center may give information about treatment to insurance companies or others to get payment.
- If the patient needs prescription medicine and it is delivered to the school, the patient may bring the medicine from school to home with no supervision.
- Health Center staff will call 9-1-1 first, and then they will call the parent or guardian if there is an emergency.
- I do not need to give permission or consent for emergency transportation.
- The patient may get medical and behavioral health care at the Henry Ford School based and Community Health Center (health center). These health services may include:

Medical Services

Services at sites with a nurse practitioner or registered nurse:

- Sick visits (illness/injury care)
- Hearing and vision screening
- Health education
- Lab testing/referrals as needed
- Immunizations (vaccines)
- Pregnancy testing and referral
- Community resources

Services at sites with a nurse practitioner:

- Checkups/wellness exams
- Sports physicals
- Care of long-term conditions, like asthma
- STI/HIV counseling, testing, and treatment

Behavioral Health Services (all sites):

- Individual or group counseling/therapy
- Psychiatry via telehealth
- Crisis intervention
- Family counseling/therapy
- Substance use counseling and referrals
- Prevention, intervention, education, & support groups

Check one of the below:

☐ I am the parent or legal guardian of the child who is under the age of 18.

☐ I am the patient named above and 18 years of age or older.

_____ _____

Signature **Date**

I agree that:

- The health center can get a copy of the patient's vaccine record from the school office, primary care provider's office, local health department, or MCIR (Michigan Care Improvement Registry).
- I understand that a form explaining any vaccines the child needs and specific vaccine information sheets (VIS) will be shared with me.
- The health center will not give the patient any vaccines until written or verbal consent has been given by the parent/guardian at the time of services.

Check one of the below:

☐ I am the parent or legal guardian of the child who is under the age of 18.

☐ I am the patient named above and 18 years of age or older.

_____ _____

Signature **Date**

HENRY FORD HEALTH

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

Intake Form: To be completed by Parent/Guardian or Patient (age 18 or over)

Patient Information

Patient's legal name (first, last, middle initial) _____

Patient's name/the name I use: _____ Pronouns: _____

Date of Birth: _____/_____/_____ Patient's sex assigned at birth: ☐ Male ☐ Female ☐ Intersex

Gender Identity: ☐ Girl/Woman ☐ Boy/Man ☐ Genderqueer or non-binary
☐ Transgender Girl/Woman ☐ Transgender Boy/Man ☐ Additional: _____

Address: _____ City: _____ Zip Code:_____

Patient Cell Number: (_____)_____-_____ Patient Email: _____

Patient's Race (optional): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ More than 1 race: _____

Ethnicity (optional): ☐ Hispanic/Latino ☐ Arab/Chaldean ☐ Non-Hispanic/Latino/Arabic

Patient's Doctor/Primary Care Physician (PCP): _____

Doctor phone number: (_____)_____-_____ Date of last physical exam: _____

Parent/Guardian (Please provide copy of legal document if not biological parent)

Last name: _____ First name: _____

Date of Birth: _____/_____/_____ Relationship to Patient: _____

Phone Number: (_____)_____-_____ 2nd Phone Number: (_____)_____-_____

Email: _____

Emergency Contact: _____Phone Number: (_____) _____-_____

Insurance Information Patient's Medical Insurance: ☐ Medicaid ☐ Private ☐ None

Name of Insurance (Ex: Molina, Meridian, HAP, BCBS, etc.): _____

Member ID Number (number on card) _____ Group Number: _____

Member name if other than patient: _____ Date of Birth: _____/_____/_____

Relationship to patient: _____

Family Information

Who does the child live with: ☐ Mother ☐ Father ☐ Grandmother ☐ Grandfather ☐ Other _____
☐ Brothers - how many? _____ ☐ Sisters - how many? _____

Are there pets in the home? ☐ Yes ☐ No

Does anyone smoke in the home? ☐ Yes ☐ No

Patient's Medical History: check yes or no for each item.

Any allergies to medicines? If yes, please list medicine and reaction: _____	☐ Yes	☐ No
Any history of severe allergic reaction or anaphylaxis?	☐ Yes	☐ No
Any food allergies? If yes, please list: _____	☐ Yes	☐ No
Any surgeries (i.e. tonsils, hernia, appendix)? If yes, please list: _____	☐ Yes	☐ No
Any mental health history (i.e. anxiety, depression)?	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bladder problems (bedwetting)	☐ Yes	☐ No
Seizure (epilepsy)	☐ Yes	☐ No
Anemia (low iron/blood count)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
High blood pressure (hypertension)	☐ 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/seasonal allergies	☐ Yes	☐ No
Other health problems If yes, please list: _____	☐ Yes	☐ No

Family History: Please check if a biological family member has died or has one of the conditions below.

☐ Unknown ☐ Patient Adopted

	Died	Mental Health	Asthma	Cancer	Diabetes	Heart Disease	High Cholesterol	Seizures	Sickle Cell	Thyroid disease
Mom	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (mom's side)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (mom's side)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandmother (dad's side)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Grandfather (dad's side)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐