The Center
for Youth Health & Wellness

Address: 2001 N. Lincoln Road

Escanaba, MI 48929

Office Hours: M 8am-5pm, T 10am-7pm,

W+TH 8am-5pm, F 8am-12pm

Phone # (906) 786-1672

Fax # (906) 786-6762

CONSENT FORM

Student Name (Last, First, MI)	Birth Date	Age	Sex	Grade
Address	City	Zip Code	Student Phone	

Race/Ethnicity: ☐ African American ☐White ☐ Hispanic/Latino ☐ Native American Indian/Alaskan ☐ Asian ☐ Native Hawaiian/Pacific Islander

Parent/Guardian Name (Last, First, MI)			Relationship to Student
Home Phone #	Work Phone #	Cell Phone #	Parent Email Address
Emergency Contact	Relationship		Telephone #
Name of Student's Physician/Clinic	Telephone #		Month & Year of Last Well Child Exam
Name of Student's Dentist	Telephone #		Last Routine Dental Exam

Insurance* (Please include copy of the insurance card – front and back: OR bring it in and we will make a copy for you)

Policy #	Group #	To find out if your family is eligible for LOW-COST or FREE healthcare coverage call toll free 1-888-988-6300. You can also apply online: www.healthcare4mi.com	
Policy Holder Name (First, Last, MI)	Policy Holder DOB		
Address	City	State	Zip

As legal parent or guardian or patient (18 years of age and older) I consent to the following statements:

- The above named may receive services at The Center for Youth Health & Wellness (CYHW) for one year following the date of the signature below.
- Any changes to this consent, including ending the consent, must be submitted in writing to The CYHW staff.
- The Center for Youth Health & Wellness and my child's primary care provider may exchange health information for continuity of care according to State and Federal laws.
- The Center for Youth Health & Wellness may obtain information from area school districts regarding child's grades, disciplinary action, and/or school attendance for program evaluation purposes.
- For the safety of my child, The Center for Youth Health & Wellness staff may share with school staff your child's check-in and check-out times at the school linked clinic.
- My child's medical and/or mental health records may be chosen, at random, as part of the clinical review process. This is required under the Center for Youth Health & Wellness's Continued Quality Improvement Plan. Records may be reviewed for quality assurance purposes. Records are only reviewed by the Directing Physician or peer clinician. All reviewers are bound by the same strict confidentiality and HIPAA regulations as our staff.
- I am under no obligation to have my child use the clinical services.
- The Center for Youth Health & Wellness may disclose protected health information regarding this visit to other entities for continuation of treatment, payment, and health care operations. If required by law, separate release forms will be used at the time of service. Billing information will be shared to the providers of care.
- I have been provided a copy of the Notice of Privacy Practices and Patient Bill of Rights.
- I understand that no patient will be turned away for lack of insurance.

Services provided at Center for Youth Health & Wellness include:

- Wellness exams & sports physicals
- Immunizations
- Concussion baseline & post-accident testing
- Nutrition Counseling
- Asthma, diabetes & weight management
- Pregnancy & STI counseling and testing
- Reproductive health services
- Acute care for sore throat, ear pain, non-emergent injuries, etc.
- Blood sugar & cholesterol testing
- Counseling services: Anxiety, depression, anger management, self-esteem, academic concerns, family or relationship issues

Parental Consent Is Not Needed for Crisis Intervention and Emergency Care, Reproductive Health Services, & HIV/STI Services

☐ By checking this box, I allow my student to access mental health services at CYHW (all statements about apply to mental health as well).

By signing this consent form, I agree to the above statements. I also certify that I am the parent/legal guardian of the student named above or the patient (18 years of age and older), and am registered with the school as such.

Signature of Parent/Guardian/Patient _____ Date _____

Student Medical History: Please check yes or no

Bee Sting Allergies	☐Yes	☐No	Seizures	☐Yes	☐No
Anemia	☐Yes	☐No	Stomach Problems	☐Yes	☐No
Seasonal Allergies	☐Yes	☐No	Heart Problems	☐Yes	☐No
Asthma	☐Yes	☐No	Bladder Problems	☐Yes	☐No
Diabetes	☐Yes	☐No	Cancer	☐Yes	☐No
Eczema/rashes	☐Yes	☐No	Headaches/migraines	☐Yes	☐No
ADD/ADHD	☐Yes	☐No	High blood pressure	☐Yes	☐No
Sickle cell disease	☐Yes	☐No	Fainting	☐Yes	☐No
Pounding of heart	☐Yes	☐No	Pneumonia	☐Yes	☐No
Shortness of breath	☐Yes	☐No	Kidney disease	☐Yes	☐No
Frequent Urination	☐Yes	☐No	Painful joints	☐Yes	☐No
Nosebleeds	☐Yes	☐No	Backaches	☐Yes	☐No
Frequent sore throats	☐Yes	☐No	Thyroid disease	☐Yes	☐No
Psychological disorder	☐Yes	☐No			

Daily Meds: _____
Condition for Meds: _____
Medication Allergies: _____
Food Allergies: _____
Past Surgeries: _____
Hospitalizations: _____
Other health problems: _____

Family Medical History Check any illnesses that relatives (ie: mother, father, aunt, uncle, grandparents or sister, brother) has: **Please note which relative has them**	
☐ Heart Problems	☐ Cancer
☐ Cholesterol	☐ Diabetes (high blood sugar)
☐ High Blood Pressure	☐ Stroke
☐ Asthma/Emphysema/Bronchitis	☐ Seizures
☐ Death under age 50 – Cause:	☐ Kidney or Thyroid Disease
☐ Sickle cell Anemia/Blood problems	☐ Other