Gwinn Teen Clinic

Marquette County Health Department
50 West M-35 Gwinn, MI 49841
Phone (906) 372-4002 - Fax (906) 372-4012

Parent/Guardian Consent Form

Please read and complete FRONT and BACK of this form. A consent form is needed for each student to be seen in the Clinic.

Student name (Last Name, First Name, Middle Initial):	Date of Birth:	Age:	Sex: Male☐ Female☐	Grade:
Address: City: Zip:		Student telephone:		Today's Date:
Name of student's employer		Your estimate of student's annual income		

Race/Ethnicity (Optional):
☐Black or African American ☐White ☐Hispanic/Latino ☐American Indian/Alaskan Native ☐Arab ☐Asian ☐Native Hawaiian/Pacific Islander

Parent/Guardian (Last Name, First Name, Middle Initial):		Relationship to Student:
Address (if different than child):		Parent E-Mail Address:
Home phone:	Cell Phone:	Work Phone:
Name of Emergency Contact:	Relationship to Student:	Telephone #:

Name of Student's Physician/Clinic:	Telephone #
Name of Student's Dentist/Clinic:	Telephone #

Insurance:
☐Medicaid ☐Blue Cross/Blue Shield ☐MI Child ☐TRICARE ☐Other:________________________________ ☐No insurance

Please provide a photocopy of both sides of your insurance card.

Policy Holder Name (Last Name, First Name, Middle Initial):	Date of Birth:	Relationship to Student:	
Address:	City:	State:	Zip:
Policy ID #:	Group #:		

I have been fully informed and I give my consent to the following:

- The Gwinn Public Schools may release information to the Gwinn Teen Clinic for the purpose of receiving treatment and the Gwinn Teen Clinic may release information to the Gwinn Public Schools for the purpose of educational case management.
- The above named student may receive all services listed on the back of this form at the Gwinn Teen Clinic. If I am requesting any changes to this consent, I will submit the changes in writing to the Center.
- Both the Gwinn Teen Clinic and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- Completion of a risk assessment by the above named student.
- This consent form will remain active and on file at the Gwinn Teen Clinic while my student is enrolled in the Gwinn Area School District unless rescinded by me in writing.
- The Marquette County Health Department to bill my health insurance carrier for services provided to my child.
- My child's height, weight and body mass index will be entered into the Michigan Care Improvement Registry (MCIR) module. Use of this module is optional for your child and you may choose to decline this service.
- The Gwinn Teen Clinic may obtain a copy of the above named student's/patient's immunization record from the student's/patient's school office, and/or their primary care provider's office.

I understand that the Gwinn Teen Clinic is in compliance with all HIPAA laws and regulations.
The Privacy Notice is available at the health center or on the website (www.mqthealth.org).
I understand that I have the right to refuse to sign this consent form; however, my child will not be able to be seen at the clinic.

Signature of Parent/Guardian: X____

Printed name: ________________________________ Date:________________

STUDENT MEDICAL HISTORY:
Please check Yes or No.

Bee sting allergies	☐Yes ☐No	Seizure (epilepsy)	☐Yes ☐No
Medication allergies (type:_______________)	☐Yes ☐No	Anemia (low iron/blood count)	☐Yes ☐No
Food allergies (type:___________________)	☐Yes ☐No	Stomach problems	☐Yes ☐No
Allergies, i.e. hay fever, dust, pollen,	☐Yes ☐No	Heart problems	☐Yes ☐No
Asthma	☐Yes ☐No	Bladder problems	☐Yes ☐No
Diabetes (high blood sugar)	☐Yes ☐No	Cancer	☐Yes ☐No
Eczema/Rashes	☐Yes ☐No	**Taking daily medication(s)** *	☐Yes ☐No
Headaches/Migraines	☐Yes ☐No	*Name of medication(s)	
ADD / ADHD	☐Yes ☐No	*Condition for medication(s)	
Hypertension (high blood pressure)	☐Yes ☐No	Surgeries (type:______________________)	☐Yes ☐No
Sickle cell (trait or disease)	☐Yes ☐No	Overnight Hospitalizations (why:__________)	☐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	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 and note what relative had them.

☐Heart Problems	☐Cancer
☐High 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

Services provided at the Gwinn Teen Clinic

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
• Physical exams for school, sports, and camp. • Treatment for acute & chronic illness & injuries • Vision/hearing screenings and follow-up • Oral/dental screening and follow-up • Immunizations • Basic laboratory services & tests • Administration of medication • Individual, group, family, and community education • Referrals for specialty services	• Gynecological services • Pregnancy testing and referrals • Sexually transmitted disease screenings, treatment, and counseling • HIV screening and referrals • Physical/sexual abuse counseling and referrals • Crisis Intervention • Substance abuse education, counseling and referrals • Mental health assessment, counseling, and referrals

PARENTAL CONSENT IS NOT NEEDED FOR CRISIS INTERVENTION AND EMERGENCY CARE

LIMITATION OF SERVICES

♦ ***NO*** **birth control pills or devices are dispensed or prescribed**

♦ ***NO*** **abortion counseling, referrals or services are provided**

Return to:

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