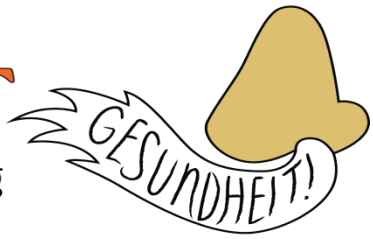
STUDENT Help & Healing Center



Dear Parent/Guardian:

In an effort to improve health care in our community, the School Linked Clinic, Student Help and Healing Center - Gesundheit! and The Sturgis Public Schools are working together to offer you more options in health care. The clinic is located at 1555 E. Chicago Rd; in the Maplecrest Plaza, north of Sturgis High School. This clinic has a designated student program – with a separate entrance and waiting area, it is used for students identified by the school as needing medical attention for preventative care, minor illness or injury, before, during or after school hours three days a week.

As the consent form indicates, please note every effort is made to contact you prior to your child being seen at the clinic. ONLY students with a signed consent form on file will be able to use the Student Help and Healing Center – Gesundheit!, with the exemption of those visits that are in accordance with Michigan law in relation to confidential services. If you do not complete and return the consent form, front and back, we understand that you do not wish to participate. Please understand this provides consent for the student's entire school career, unless you choose to remove this consent. To remove consent at any time, please complete a withdraw form which can be obtained at the clinic during normal business hours.

Services at Student Help and Healing Center - Gesundheit! do not replace your primary health care provider. These visits will be shared with your regular providers' office. The Student Help and Healing Center is available for students to receive prompt, necessary health care with a more convenient access. If you wish to participate, please complete both sides, sign and return to your child's school office.

If you would like additional information in regards to the Student Help and Healing Center - Gesundheit!, please feel free to stop in or contact the clinic at 1 (269) 659-6519.

Yours in Health,

Jo Hagood
Vice President of Practice Management
Sturgis Hospital

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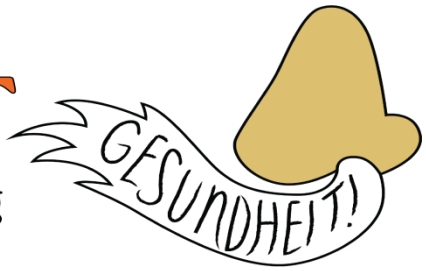

SERVICES PROVIDED at SCHOOL LINKED CLINIC

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 & Vision
- Dental Referral
- Basic Laboratory Services & Tests
- Administration of medication(s)
- Referrals for Specialty Services

BEHAVIORAL HEALTH SERVICES:

- Assessment
- Case Management
- Education
- Individual, group & family therapy
- Referrals for Psychiatric Services &
- Medication Management
- **Referrals** for Specialty Services & medication management

TRANSPORTATION

- High School students will be able to walk or drive to the clinic during or after school hours.
- Transportation of Middle School students will need to be provided by a parent. We will be exploring options throughout the year.

Current Michigan Law allows for confidential services to minors ages 14 and above without the consent of a parent or guardian in these areas:

CONFIDENTIAL AND BEHAVIORAL HEALTH SERVICES

- Reproductive Health Services
- Pregnancy related services & referrals
- Sexually transmitted disease education, screenings, treatment & counseling
- HIV education, screening & referrals
- Physical/sexual abuse education, counseling & referrals
- Crisis Intervention
- Substance abuse education, counseling & referrals
- Behavioral health education, assessment, therapy & referrals.
- Individual counseling
- Students may access confidential services at their request during school hours.

LIMITATION OF SERVICES

- ***NO*** abortion counseling, referrals or services are provided at the **Student Help and Healing Center – Gesundheit!**

SCHOOL LINKED CLINIC
PARENT/GUARDIAN/PATIENT (18 AND OVER) DEMOGRAPHIC FORM

Patient Last Name, First	Date of Birth	Male ☐ Female ☐	Grade
Patient email			Patient Cell
Race (Optional): ☐ Black/African American ☐ Asian	☐ Caucasian/White ☐ American Indian/Alaskan Native	☐ Native Hawaiian/Other Pacific Islander ☐ Refused to Report	
Ethnicity (Optional) ☐ Hispanic/Latino	☐ Arabic	☐ Non-Hispanic/Latino/Arabic	

Address	City	Zip code	Parent Email Address
Parent/Guardian: Last Name	First Name	M.I.	Relationship to Patient
Parent/Guardian: Last Name	First Name	M.I.	Relationship to Patient
Day time/Work Phone #	Evening #		Parent Cell #
Emergency Contact	Relationship to Patient		Phone #
Additional Emergency Contact	Relationship to Patient		Phone #
Patient's Doctor	Date of Last Physical		Phone #
Medical Insurance Type:	Member ID #		Group #
Member Name (parent/guardian)	Member Birthdate		Relationship to Patient
Pharmacy Preference			

☐ **By <u>not</u> checking this box, I am giving consent to the Student Help and Healing Center to send newsletters and clinic updates via email. The clinic will not send medical records, confidential information, or any medically related information via email.**

I consent to all of the following:

- The above named student may receive all services at the Student Help and Healing Center – Gesundheit!.
- The Student Help and Healing Center – Gesundheit! may release information regarding treatment to third party payers or others for the purpose of receiving payment for services.
- The Student Help and Healing Center – Gesundheit! 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.

Permission to Leave Messages at the telephone numbers provided: I hereby authorize my child's physician or practice staff to leave messages on the following telephone number: _____ pertaining to my child's appointments and medical care.
_____ Yes _____ No.

By signing this consent form, I certify that I am the guardian of the above named patient under the age of 18; or the patient named above if not a minor. I understand that I may withdraw my consent for services upon written notice of the Student Help and Healing Center – Gesundheit! at any time.

I acknowledge receiving a copy of the Sturgis Hospital Notice of Privacy Practices.

_____ _____
Signature of Parent/Guardian/Patient (18 and Older) Date

STUDENT & FAMILY MEDICAL HISTORY FORM

STUDENT MEDICAL HISTORY:

Bee sting allergies ☐ Yes ☐ No	Have you had any problems with childhood vaccines? ☐ Yes ☐ No Explain:	Overnight Hospitalizations ☐ Yes ☐ No Reason:
Medication allergies ☐ Yes ☐ No Type:	Have you had chickenpox vaccines? ☐ Yes ☐ No	Surgeries: ☐ Yes ☐ No Type:
Food allergies (i.e. eggs, yeast) ☐ Yes ☐ No Type:	Have you had chickenpox disease? ☐ Yes ☐ No **If yes, please provide approximate month & year** _____	Daily medications ☐ Yes ☐ No Name(s):
Allergies, (i.e. hay fever, dust, pollen ☐ Yes ☐ No Type:	Pneumonia ☐ Yes ☐ No	Conditions for medications ☐ Yes ☐ No
Asthma ☐ Yes ☐ No	Kidney Disease ☐ Yes ☐ No	Seizure (epilepsy) ☐ Yes ☐ No
Diabetes (high blood sugar) ☐ Yes ☐ No	Painful Joints ☐ Yes ☐ No	Anemia (low iron/blood count) ☐ Yes ☐ No
Eczema/Rashes ☐ Yes ☐ No	Pounding of Heart ☐ Yes ☐ No	Stomach problems ☐ Yes ☐ No
Headaches/Migraines ☐ Yes ☐ No	Shortness of Breath ☐ Yes ☐ No	Heart Problems ☐ Yes ☐ No
ADD/AHD ☐ Yes ☐ No	Frequent Urination ☐ Yes ☐ No	Bladder Problems ☐ Yes ☐ No
Hypertension (high blood pressure) ☐ Yes ☐ No	Nosebleeds ☐ Yes ☐ No	Other Health Problems ☐ Yes ☐ No
Sickle Cell (trait or disease) ☐ Yes ☐ No	Frequent Sore Throats ☐ Yes ☐ No	_____
Fainting ☐ Yes ☐ No	Backaches ☐ Yes ☐ No	_____
Depression ☐ Yes ☐ No	Anxiety ☐ Yes ☐ No	Substance Abuse Disorder ☐ Yes ☐ No

FAMILY MEDICAL HISTORY:

Please check the diseases/conditions in child's family	Please note which relative has/had this condition (Mother, Father, Brother/Sister, Grandparent, Aunt/Uncle
☐ Heart Problems	
☐ High Cholesterol	
☐ High Blood Pressure	
☐ Asthma/Emphysema/Bronchitis	
☐ Death Under Age 50 - Cause:	
☐ Cancer	
☐ Diabetes (High Blood Sugar)	
☐ Stroke	
☐ Seizures	
☐ Kidney	
☐ Sickle Cell Anemia/Blood Problems	
☐ Depression	
☐ Anxiety	
☐ Substance Abuse Disorder	
☐ Other	

1.	Would you like information from our staff regarding:	
	Options for health insurance?	☐ Yes ☐ No
	Finding a health care provider (doctor or nurse practitioner)?	☐ Yes ☐ No
	Finding a dentist?	☐ Yes ☐ No
2.	Do you or your family members have anything you would like to discuss with the Mental Health provider?	☐ Yes ☐ No
	Do you (the parent) have concerns about your child's emotional well-being?	☐ Yes ☐ No
	Do you (the student) have concerns about your emotional well-being?	☐ Yes ☐ No
3.	Are you concerned about your income meeting the basic needs for yourself or your family?	☐ Yes ☐ No
	Please circle your concerns: Food Clothing Housing Paying for bills for heat and water Transportation	
	If you answered YES to any of the above, a member of our staff will contact you	

Is there anything else you would like us to know about you?

_____

_____

Reviewed with client _____ _____
Initials Date