VAN DYKE PUBLIC SCHOOL DISTRICT
REGISTRATION REQUIREMENTS FOR LINCOLN HIGH SCHOOL

Parent of the Child(ren) resides Within the Boundaries
(Regardless of whether the child(ren) reside(s) with that parent)
Standard Proof of Residency

You must bring in a **CURRENT ORIGINAL** of **ONE** of the following:
(Showing parent/guardian name and address within district)

- Driver's License
- State ID

-AND-

ONE ORIGINAL of the following: (Copy to be retained by VDPS)

- Current Signed Lease (with landlord info)
- Closing Statement
- Current Mortgage Statement/Book
- Current Property Tax Bill
- Deed/Title

-AND-

- Probate Court Guardianship Paper (if applicable)

- IF A STUDENT RECEIVES SPECIAL SERVICES, A COPY OF THE MOST RECENT IEP IS NEEDED

You must bring in a ***CURRENT ORIGINAL** of **ONE** of the following:
(Showing parent/guardian name and address within the district)

- Gas and/or Electric Bill
- Current Bank Statement
- Cable Bill
- Payroll/Social Services/Social Security Check
- Auto Insurance Statement or Bill
- Home Insurance Policy or Bill
- Car Registration
- Current Major Credit Card Statement

***A current bill covers a service period ending within 30 days of the date of registration.**

-AND-

Student(s)

- **ORIGINAL BIRTH CERTIFICATE**
- **IMMUNIZATION RECORD**
- **TRANSCRIPT, WITHDRAWL GRADES, MOST RECENT REPORT CARD**
- **ATTENDANCE AND DISCIPLINE RECORD FROM PREVIOUS SCHOOL**

VAN DYKE PUBLIC SCHOOLS – ENROLLMENT FORM

STUDENT INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Address: _____

City: _____ Zip Code: _____

Sex: *Male* _____ *Female* _____

Date of Birth: MO_____ DAY_____ YEAR_____

City & State *or* Place of Birth: _____

Date of First DPT Booster: _____

Home Telephone Number: (___) _____

Beeper/Pager Number: (___) _____

Cell Phone Number: (___) _____

PARENT INFORMATION

Father: _____
First Name *Last Name*

Address: _____
Number *Street*

City: _____ Zip Code: _____

Mother: _____
First Name *Last Name*

Address: _____
Number *Street*

City: _____ Zip Code: _____

Step-Parent: _____
First Name *Last Name*

Address: _____
Number *Street*

City: _____ Zip Code: _____

With whom does student reside? ☐ Father ☐ Mother
☐ Stepmother ☐ Stepfather ☐ Guardian ☐ Other_____

Is the student or has the student been in Special Education classes? Yes_____ No_____

What, if any, special help or care does your child require? Please explain._____

_____

_____

_____

_____

_____ _____
Signature of Parent/Guardian *Date*

SCHOOL INFORMATION

Name of last school attended: _____

Address: _____
City *State* *Zip Code*

Name of last school district: _____

Did your child ever attend any other Van Dyke School?
☐ Yes ☐ No

If YES, what school and when?
Name of School: _____
School Year Attended: _____

-OTHER CHILDREN IN FAMILY-

Name of Child	*Sex*	*Date of Birth*

State Board of Education Approved Home Language Survey

The Van Dyke School District is collecting information regarding the language background of each of its students. This information will be used to determine the number of children who should be provided bilingual instruction according to Sections 380.1151-380.1158 of the School Code of 1976, Michigan's Bilingual Education Law.

1) Is your child's native language English? Yes____ No_____

What is the native language? _____

2) Is English used in your home most of the time?
Yes____ No_____

What is the language used at home? _____

3) Is your child Multi-Racial? Yes_____ No_____

If **YES**, mark with percentage, **all** categories that best describe your child's origin.
If **NO**, mark only **one** category 100%.

American Indian *or* Alaskan Native_____
Asian American_____
Black *or* African American_____
Hispanic *or* Latino_____
Native Hawaiian *or* Other Pacific Islander_____
White_____

Please identify your child's racial background, by percentages, in the spaces provided above.

REGISTERING AT: _____

CURRENT GRADE: _____

- OFFICE USE ONLY -

☐ IMMUN ☐ ORIG. B/C ☐ PROOF OF RES ☐ EMG CARD
☐ REQUEST FOR RECORDS ☐ HOUSEHOLD SURVEY
☐ CONCUSSION FORM

STUDENT #_____

PERSON TAKING REGISTRATION_____

for enrollment and placement of the enrolling student(s).

STUDENT REGISTRATION - PLACEMENT AGREEMENT

PROVIDING FALSE INFORMATION WILL RESULT IN YOUR CHILD BEING DISENROLLED AND THE POSSIBILITY OF LEGAL ACTION DUE TO RESIDENCY FRAUD.

Student Name:_____

I understand, due to the high standards of Van Dyke Public Schools, that my child will be registered and placed in classes, only if the following criteria are met. His/her registration and placement, is temporary and contingent upon verification of the following items:

- Academic achievement is determined by most recent report card
- That there are no previous actions taken toward expulsion
- Evidence that registrant a resident of Van Dyke Public School District
- Parent/Legal Guardian must provide a valid driver's license or State issued picture identification card
- Valid telephone number must be provided for emergency contact
- Proof of student's date of birth (Student's original Birth Certificate)
- Up-to-date Immunization Record (required)

PROOF OF RESIDENCY consists of:

- Purchase Agreement or closing papers or City of Warren Tax document
- Lease or Rental Agreement
- Current Driver's License or State I.D.
- Current Voter's registration
- Current Utility Bill(s)
- Notarized District Affidavit of Residency (if living with friend or relative)
- Court Order

Every parent/legal guardian registering a child must prove residency within our school district's boundaries.* It is the responsibility of the parent to provide proof of residency upon enrollment. You must provide three pieces of residency proof – of these one must be a purchase agreement, closing papers, City of Warren property tax documentation, lease or rental agreement. **The student must reside at this address.**

If a student is registering under the rules of Power of Attorney, all of the above stated requirements still govern registration. The student must reside at the home of the person assuming Power of Attorney. At any time, a home visit may occur. (Completed, notarized, district Power of Attorney is valid for 6 months from the date issued. Therefore, two are required per school year.)

_____

I, _____, **certify that I have read, understand, and have**
Name of Parent/Legal Guardian

provided the above information. It is true and complete. Parents/Guardians providing false information for registration may have their child(ren) subject to disenrollment from Van Dyke Public Schools.

_____ _____

Signature of Parent/Legal Guardian *Date*

* Macomb County students residing outside of our district's boundaries must submit an application to attend Van Dyke Public Schools during the open enrollment times. These students must have applications processed and approved through the Van Dyke Public Schools Administrative Service Center (Office for Curriculum and Instruction) under our district's Schools of Choice Plan.

Van Dyke Public Schools
23500 MacArthur Blvd.
Warren, Michigan 48089-1741
Phone: (586) 758-8341
Fax: (586) 759-9408

REQUEST FOR RELEASE OF SCHOOL RECORDS / CONSENT TO SEND OR RECEIVE CONFIDENTIAL RECORDS

Name of Last School District:		
Name of Last School Attended:		
Street Address:		
City:	State:	Zip Code:
Phone Number:	Fax Number:	

Name of Student	*Date of Birth*	*Grade*

The above student recently enrolled in the Van Dyke Public School District.
Please forward the complete records of the above named student to the school or department indicated below:

CHECK ALL THAT APPLY	*Building*	*Phone Number*	*Fax Number*	*Attention*
X	Lincoln High School 22900 Federal Blvd. Warren, MI 48089	(586) 758-8306	(586) 758-8304	Counseling Office
	Lincoln Middle School 22500 Federal Blvd. Warren, MI 48089	(586) 758-8325	(586) 427-3508	Counseling Office
	Carlson Elementary School 12355 Mruk Warren, MI 48089	(586) 758-8345	(586) 758-7397	Principal
	Lincoln Elementary School 22100 Federal Ave. Warren, MI 48089	(586) 758-8342	(586) 758-7381	Principal
	McKinley Elementary School 13173 Toepfer Warren, MI 48089	(586) 758-8365	(586) 427-3658	Principal
	Van Dyke Public Schools Special Services Department 23500 MacArthur Blvd. Warren, MI 48089	(586) 758-8338	(586) 759-6791	Director

CHECK ALL THAT APPLY	*Please include with these records all educational and confidential information including but not limited to: All academic records, achievement test results, all medical health records and doctor's reports, Special Education records, psychological and/or diagnostic test results, social worker / counselor reports, summary or attendance reports, and any other pertinent information.*
X	I hereby give permission to have all of my child's confidential records sent to Van Dyke Public Schools.
	I hereby give consent for the release of all Special Education, and confidential records including medical, psychiatric, psychological, social and school information concerning my child. Please send all Special Education to the Special Services Department listed above.
	I confirm that this child has not been expelled from a former school or has not been allowed to withdraw from a former school pending any charges due to a "Weapons in Schools", "Physical or Verbal Assault", "Arson", or "Criminal Sexual Conduct" infraction.

Signature of Parent/Guardian:	Date:

Van Dyke Public Schools
23500 MacArthur Blvd.
Warren, MI 48089
(586) 758-8341

Billie Szepaniak, Principal, Lincoln High School
Phone: 586-758-8306
Fax: 586-758-8304

Name of Student:_____ Date of Birth:_____
School wanting to attend in Van Dyke Public Schools: LINCOLN HIGH SCHOOL Grade:_____

AFFIRMATION OF PRIOR DISCIPLINE RECORD

This completed form must accompany your Enrollment Packet.

A willful false statement on this affirmation will result in a report to the appropriate authorities and immediate discontinuation of enrollment.

Directions: Check either Paragraph 1 or 2 below, sign and provide all appropriate information.

Paragraph 1:

_____ The undersigned affirms that the above named student has not been suspended or expelled from a public or private school in Michigan or any other state.

Student Signature:_____ Date:_____

Parent Signature:_____ Date:_____

Paragraph 2:

_____ The undersigned affirms that the above named student has been suspended or expelled from a public or private school in Michigan or any other state.

Student Signature:_____ Date:_____

Parent Signature:_____ Date:_____

If Paragraph 2 has been checked, please explain the circumstances in detail. Include the school name, dates of suspension/expulsion, and a description of the incident(s). Use the back of this form if additional space is needed.

_____

_____

_____

_____

This section must be completed by the appropriate representative from the previous school district.

Name of Previous School District:_____

Name of Previous School:_____ Last date of attendance:_____

Please check one of the following:

_____ According to our records, the information provided by the parent/guardian is correct.

_____ According to our records, the information provided by the parent/guardian is not correct.

Were there attendance, tardiness or truancy issues with this student? ____ Yes ____ No

Signature of Administrator:_____ Title:_____

Telephone Number:_____ Date:_____

Acceptable Use Policy for the Internet, Local Area Network, Computers, and Related Technology Equipment

The Internet is a complex association of governmental, business and educational agencies working together to share resources. The Internet provides access to electronic mail, college and university institutions, tours of museums, and the opportunity to exchange information with people throughout the world. However, along with the use of the Internet comes new responsibilities. Please read the Policy on the reverse side of this form carefully.

Access and use of the Internet is a conditional right for students and employees. The Van Dyke Public Schools has developed an Internet Acceptable Use Policy (reverse side of this form) to cover the use of this technological tool.

INDIVIDUAL ACCESS RELEASE FORM

(Student/Employee)

As a condition of my right to use the technology facilities of the Van Dyke Public Schools, I have read, understand and agree to follow the Acceptable Use Policy of the Van Dyke Schools. In addition, I will promote this agreement with students and/or staff to ensure the appropriate use of the Internet in the Van Dyke Public Schools.

_____ _____

Signature of Individual School/Location

_____ _____

Printed Name of Individual Date

PARENT OR GUARDIAN AGREEMENT

Student Name_____ Birth Date_____ Age ____

(If student is under 18 years of age, a parent or guardian must also read and sign this agreement.)

As the parent or guardian of this student, I have read the Van Dyke Public School District's Acceptable Use Policy. I understand that access to computers, Networks, etc. is designed for educational purposes. The Van Dyke Public School District has taken precautions to eliminate controversial material. However, I also recognize it is impossible for the Van Dyke Public School District to restrict access to all controversial materials on the Internet and I will not hold them responsible for materials acquired on the network. Further, I accept full responsibility for supervision if and when my child's use of the computer is not in a school setting. I hereby give permission to issue access for my child and certify that the information contained on this form is correct.

Parent or Guardian's Name (Please Print): _____

Signature:_____ Date: _____

Parents/Students: Please return the white copy of this completed form to your classroom teacher or school office. Retain the pink copy for your records.

School: _____

Employees: Please return the white copy of this completed form to your school office or department director. Retain the pink copy for your records.

School/Department: _____

Internet Acceptable Use Policy on reverse side of this form.

Van Dyke Public Schools
Warren, MI 48089

Social and Public Media Release Form

Photos and video are taken in the district on an ongoing basis. The Van Dyke Public Schools likes to showcase its staff and students, and some of this information may occasionally end up featured in the school buildings, in local newspapers, or on social media.

This form will allow your student to be photographed or video recorded with the purpose of sharing activities with our school community and/or in the media, including social media (See below.).**

This form releases the Van Dyke Public School District from any and all claims for libel and invasion of privacy arising from said recording regardless of nature.

By returning this form, you are letting us know whether or not you grant consent for pictures of your child to be included in school correspondence and social or public media, which may include the following:

- Local newspapers, e.g. Warren Weekly, Macomb Daily
- Facebook for Van Dyke Public Schools or individual schools
- Van Dyke Public Schools Website
- Teacher Web Pages
- Other School-Related Social Media

Student's name: _____

School: LHS Grade: _____

Teacher's name if Elementary: _____

Signature of parent or legal guardian: _____

Date: _____

_____ **Yes, I grant my consent to use photograph/film of my child as stated above.**

_____ **No, I do not consent to use photograph/film of my child as stated above.**

**If no form on file, do not use photograph or film of student.

July 2014

Student Data Form
Lincoln High School

Student Information

Name	Grade (Circle One) 9 10 11 12	Date of Birth
Home Street Address	Home City & Zip	Home Phone
Mailing Street Address	Mailing City & Zip	Alternate Phone
Gender (Circle One) Female Male	Home Phone Unlisted? YES NO	Alternate Phone Unlisted? YES NO

Health

Preferred Hospital				
Medical Alerts, Allergies or Problems				
Physical Limitations				
Physician Name		Physician Phone		
Dentist Name		Dentist Phone		
Asthma	Diabetes	Vision Problem	Hearing Problem	Heart Condition

Contact 1

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

Contact 2

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

OVER →

Contact 3

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

Contact 4

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

Contact 5

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

Contact 6

Name	Relationship	Contact Priority
Street Address	City & Zip	Home Phone
Cell Phone	Cell Phone 2	Lives with Student? YES NO
Employer	Work Phone	Work Extension
Email Address		Receives Letter Mailing? YES NO

I certify that the information on this form is true and correct to the best of my knowledge.

Parent/Guardian Signature _____ Date _____

Van Dyke Public Schools
Warren, MI 48089

Dear Parent(s):

Our intent in providing this form is to be certain that your child's teacher(s) be aware of any problems your child may have. At this time, we are asking that you bring us up to date regarding any physical or emotional problems that your child may have. All information will be kept confidential.

Fill in your child's name, grade, room number, and write NONE across the form if your child has no problems.

Please feel free to contact your child's school office if you have any questions or need to update your information during the school year.

Thank you for your cooperation.

Student Health Information

Student Information			
	Last Name	First Name	Middle Name
	Date of Birth	Grade	
	Room Number	Building	

Description of Problem:

Restrictions for child, if any:

List any prescribed medications:

Name of Doctor and/or Psychologist:
Phone Number:
Additional Information (optional):

Signature of Parent / Legal Guardian _____ Phone Number _____ Date _____

Educational Material for Parents and Students (Content Meets MDCH Requirements)

Sources: Michigan Department of Community Health, CDC and the National Operating Committee on Standards for Athletic Equipment (NOCSAE)

UNDERSTANDING CONCUSSION

Some Common Symptoms

Headache	**Balance Problems**	**Sensitive to Noise**	**Poor Concentration**	**Not "Feeling Right"**
Pressure in the Head	**Double Vision**	**Sluggishness**	**Memory Problems**	**Feeling Irritable**
Nausea/Vomiting	**Blurry Vision**	**Haziness**	**Confusion**	**Slow Reaction Time**
Dizziness	**Sensitive to Light**	**Fogginess**	**"Feeling Down"**	**Sleep Problems**
		Grogginess		

WHAT IS A CONCUSSION?

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a fall, bump, blow, or jolt to the head or body that causes the head and brain to move quickly back and forth. A concussion can be caused by a shaking, spinning or a sudden stopping and starting of the head. Even a "ding," "getting your bell rung," or what seems to be a mild bump or blow to the head can be serious. A concussion can happen even if you haven't been knocked out.

You can't see a concussion. Signs and symptoms of concussions can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If the student reports any symptoms of a concussion, or if you notice symptoms yourself, seek medical attention right away. A student who may have had a concussion should not return to play on the day of the injury and until a health care professional says they are okay to return to play.

IF YOU SUSPECT A CONCUSSION:

1. **SEEK MEDICAL ATTENTION RIGHT AWAY –** A health care professional will be able to decide how serious the concussion is and when it is safe for the student to return to regular activities, including sports. Don't hide it, report it. Ignoring symptoms and trying to "tough it out" often makes it worse.

2. **KEEP YOUR STUDENT OUT OF PLAY –** Concussions take time to heal. Don't let the student return to play the day of injury and until a heath care professional says it's okay. A student who returns to play too soon, while the brain is still healing, risks a greater chance of having a second concussion. Young children and teens are more likely to get a concussion and take longer to recover than adults. Repeat or second concussions increase the time it takes to recover and can be very serious. They can cause permanent brain damage, affecting the student for a lifetime. They can be fatal. It is better to miss one game than the whole season.

3. **TELL THE SCHOOL ABOUT ANY PREVIOUS CONCUSSION –** Schools should know if a student had a previous concussion. A student's school may not know about a concussion received in another sport or activity unless you notify them.

SIGNS OBSERVED BY PARENTS:

- Appears dazed or stunned
- Is confused about assignment or position
- Forgets an instruction
- Can't recall events prior to or after a hit or fall
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows mood, behavior, or personality changes

CONCUSSION DANGER SIGNS:

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. A student should receive immediate medical attention if after a bump, blow, or jolt to the head or body s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people/places
- Becomes increasingly confused, restless or agitated
- Has unusual behavior
- Loses consciousness (even a brief loss of consciousness should be taken seriously.)

HOW TO RESPOND TO A REPORT OF A CONCUSSION:

If a student reports one or more symptoms of a concussion after a bump, blow, or jolt to the head or body, s/he should be kept out of athletic play the day of the injury. The student should only return to play with permission from a health care professional experienced in evaluating for concussion. During recovery, rest is key. Exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse. Students who return to school after a concussion may need to spend fewer hours at school, take rests breaks, be given extra help and time, spend less time reading, writing or on a computer. After a concussion, returning to sports and school is a gradual process that should be monitored by a health care professional.

Remember: Concussion affects people differently. While most students with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

To learn more, go to www.cdc.gov/concussion.

Parents and Students Must Sign and Return the Educational Material Acknowledgement Form

PARENT & STUDENT CONCUSSION INFORMATION SHEET
ACKNOWLEDGMENT OF RECEIPT

By my name and signature below, I acknowledge that I have received and reviewed the Concussion Information Sheet for parents and students provided by Van Dyke Public Schools.

Student Name	Parent Name
Student Signature	Parent Signature
	Date

Return this signed form to your child's school.

Van Dyke Public Schools

Consent for Disclosure of Immunization Information to Local and State Health Departments

Immunizations are an important part of keeping our children healthy. Schools and State and Local health departments must monitor immunization levels to ensure that all communities are protected from potentially life-threatening diseases and, if necessary, respond promptly to an emerging public health threat. It is important that disease threats be minimized through the monitoring of students being immunized.

Sharing immunization and personally identifiable information including the students name, Date of Birth, gender, and address with local and state health departments will help to keep your child safe from vaccine preventable diseases. The Family Educational Rights and Privacy Act (FERPA), 20 U.S.C.-1232g, requires written parental consent before personally identifiable information from your child's education records is disclosed to the health department. If your child is 18 or over, he or she is an "eligible student" and must provide consent for disclosures of information from his or her education records.

You may withdraw your consent to share this information in writing at any time.

I authorize Van Dyke Public Schools to release my child's immunization record to the Michigan Department of Health and Human Services and Local Health Department. I understand this information will be used to improve the quality and timeliness of immunization services and to help schools comply with Michigan Law. This includes any immunization information and limited personally identifiable information from the school.

Student's Name: _____ Date of Birth__/__/__

Signature of Parent/Guardian
or Eligible Student: _____ Date:__/__/__

Printed Parent/Guardian Name: _____

Van Dyke Public Schools
Every Student, Every Day, No Matter What

Food Service Department
23500 MacArthur Boulevard
Warren, MI 48089

Phone: 586.758.8335

Dear Parent or Guardian:

We are pleased to inform you that Van Dyke Public Schools will be participating in the Community Eligibility Provision (CEP) as part of the National School Lunch and School Breakfast Programs for the School Year 2019-2020.

The GREAT NEWS is that ALL students enrolled at our school can receive a healthy breakfast and lunch at NO CHARGE to your household each day.

In place of the Free and Reduced-Price Meal Application we still need your household to **fill out and sign the Household Information Report**. This report is *critical* in determining the amount of money that our school receives from a variety of State and Federal supplemental programs like Title I A, At-risk (31a), Title II A, E- Rate, etc.

These supplemental programs have the potential to offer supports and services for our students including, but not limited to:

- Instructional supports (staff, supplies & materials, etc.)
- Non-instructional services (counseling, social work, health services, etc.)
- Professional Learning for staff
- Parent and Community engagement supplies and activities
- Technology

We are asking that you please complete and submit it as soon as possible to ensure that additional funding for our school is available to meet the needs of our students. All information on the report submitted is confidential. Without your assistance in completing and returning the attached report, our school cannot maximize the use of available State and Federal funds.

If we can be of any further assistance, please contact us at 586-758-8335.

Sincerely,

Doreen Grout
Food Service Director

INSTRUCTIONS FOR COMPLETING THE
HOUSEHOLD INFORMATION REPORT

A HOUSEHOLD MEMBER IS ANY CHILD OR ADULT LIVING WITH YOU.

IF ANY MEMBER OF YOUR HOUSEHOLD RECEIVES BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), FAMILY INDEPENDENCE PROGRAM (FIP), OR FDPIR PLEASE FOLLOW THESE INSTRUCTIONS:

Part A: Enter the total number of individuals living in your household, including all children in the box provided.

Part B: List the case number for any household member (including adults) receiving FAP, FIP, or FDPIR benefits

Part C: List the First and Last name, Birth Date, School that the child is attending, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part D: Skip this part

Part E: Sign the form. Print your name and Date.

IF YOUR HOUSEHOLD DOES NOT RECEIVE BENEFITS FROM THE FOOD ASSISTANCE PROGRAM (FAP), FAMILY INDEPENDENCE PROGRAM (FIP), OR FDPIR PLEASE FOLLOW THESE INSTRUCTIONS:

Part A: List the total number of individuals living in your household, including all children.

Part B: Skip this part.

Part C: List the First and Last name, Birth Date, School that the child is attending, and H if homeless, M if Migrant, R if Runaway or F if a Foster Child.

Part D: Enter all gross income for each type of income that applies. If you have no income for any 1 or more of the categories, Circle NONE if no income. Add lines 1-6 and enter the Total Monthly Household Income.

Part E: Sign the form. Print your name and Date.

Van Dyke Public Schools
23500 MacArthur
Warren, MI 48089

Household Information Report

To determine eligibility for various additional state and federal program benefits that your school may qualify for, please complete, sign and return this report to _____.
(School Name)

These sections must be completed by the head of household or designee.

PART A. SIZE OF FAMILY - Enter the total number of individuals living in your household, including all adults and children → _____

PART B. CURRENT BENEFITS - Complete below if applicable

If any member of your household receives Food Assistance Program (FAP), Family Independence Program (FIP), or FDPIR, provide the name and case number for the person who receives benefits. Bridge Card Numbers and Medicaid Numbers are NOT ACCEPTABLE case numbers.

Name: _____ Case Number: _____

PART C. STUDENT INFORMATION – Complete for each student Pre-K through 12th Grade

Last Name	First Name	Birth Date XX-XX-XXXX	School	Identify H if Homeless M if Migrant R if Runaway F if Foster

If you need additional lines, attach a second sheet to this report or attach a copy of this report clearly marked as a Page 2.

PART D. TOTAL MONTHLY HOUSEHOLD INCOME – Report income for all members of household excluding Foster Children. If you have reported a case number above, you do not need to fill in this section. Simply sign and date form.

Type of Income	Income	Circle if None
1. Gross Monthly Earnings: Wages, Salary, Commissions	$	None
2. Monthly Welfare Payments, Child Support, Alimony	$	None
3. Monthly Payments from Pensions, Retirement, Social Security	$	None
4. Monthly Dividends or Interest on Savings	$	None
5. Monthly Worker's Compensation, Unemployment, Strike Benefits	$	None
6. Other Monthly Income (SSI, VA, Disability, Farm, other)	$	None
Total Monthly Household Income (Add lines 1-6)	$	

PART E. SIGNATURE - I certify (promise) that all information on this report is true and that all income is reported. I understand that the school will get federal/state funds based on the information I give. I understand that school officials may verify (check) the information.

_____ (Signature) _____ (Printed Name) _____ (Date)

_____ (Address) _____ (City) _____ (Zip)

_____ (Home Phone) _____ (Work Phone) _____ (Email Address)

By providing your email address you may be contacted via email by the district.

Henry Ford Health System

SCHOOL-BASED
& COMMUNITY HEALTH
PROGRAM

Henry Ford Health System's Department of Pediatrics, School-Based and Community Health Program is planning to expand services to students on the campus of Lincoln High School beginning in August 2019. **Minor sick visits using virtual care, and behavioral health services with be provided to persons 4 through 21 years of age, and special education clients up to age 26.** Services include:

- Behavioral health counseling
- Basic Primary Care
- Telemedicine
- Health Assessment
- Health Education
- Diagnosis and treatment of minor injuries and illnesses

The health center will be open year-round.

Proposed hours are
Monday through Friday
07:30 am to 3:30 pm.
Appointments are preferred; walk-ins may be subject to longer wait times and availability
(Hours may change, please call ahead)

ALL STUDENTS CAN RECEIVE CARE REGARDLESS OF THEIR HEALTH INSURANCE STATUS, LEGAL STATUS, and/or ABILITY TO PAY

We accept all health insurances. If your family needs health insurance, we can provide insurance application assistance at the health center.

Please complete the two sided form following this letter, including the insurance information and health history questions and return it to the clinic or the school's main office. This form grants us permission to provide services to your child.

If you have any questions or need additional information, please call the Henry Ford School Based and Community Health Program at (313) 874-5426.

We look forward to seeing you in the Fall of 2019,
Henry Ford Health System School-Based and Community Health Staff

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

PATIENT (18 and OVER) OR GUARDIAN CONSENT FORM

Name: Last	First	M.I.	**Pronouns:**	**Grade:**
Name on Insurance: Last	First	M.I.	**Date of Birth:** **Month** / **Day** / **Year**	

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Parent Cell Phone** ( ) **Parent Email address:**	**Work/Alternate Phone** ( ) **Ok to leave voicemail?** ☐ Yes ☐ No	**Patient Cell Phone** ( ) **Ok to text?** ☐ Yes ☐ No
Address		**City**	**Zip Code**
Name of Emergency Contact	**Relationship to Patient**	**Telephone Number**	

What is the patient's (your) gender identity?			**What was patient's (your) sex assigned at birth?**
☐ Girl/Woman	☐ Transgender Girl/Woman		☐ Male ☐ Intersex
☐ Boy/Man	☐ Transgender Boy/Man		☐ Female ☐ Don't know
☐ Genderqueer or non-binary	☐ Additional identity (fill in)_____		**Were you adopted?** ☐
Race (Optional):	☐ Black/African American	☐ White	☐ Native Hawaiian/ Other Pacific Islander
	☐ American Indian/Alaskan Native	☐ Asian	☐ More than one race
Ethnicity (Optional):	☐ Hispanic/Latino	☐ Arab/Chaldean	☐ Non-Hispanic/Latino/Arabic

Medical Insurance Type:	**Member ID Number**	**Group Number**
Insurance Member Name (parent/guardian/self)	**Member Birth Date** / /	**Relationship to Patient**
IF PATIENT IS UNDER 18 Please provide the following information of the PARENT OR GUARDIAN: Last Name: First Name: M.I. Date of Birth: / / Relationship To Patient:		

PATIENT MEDICAL HISTORY: Please Check 'Yes' or 'No' for each item listed below

When was last physical?	
Any allergies to medications? If yes, please list medication and reaction:	☐Yes ☐No
Any history of severe allergic reaction or anaphylaxis?	☐Yes ☐No
Any food allergies? If yes, please list:	☐Yes ☐No
Any medications on a daily basis? If yes, please: list medication and dose:	☐Yes ☐No
Any surgeries (i.e., tonsils, hernia, appendix). If yes, please list type of surgery:	☐Yes ☐No
Any mental health history (i.e. anxiety, depression):	☐Yes ☐No

Does the patient have any of the following:	
Asthma	☐Yes ☐No
Bladder problems (bedwetting)	☐Yes ☐No
Seizure (epilepsy)	☐Yes ☐No
Anemia (low iron/blood count)	☐Yes ☐No
Diabetes	☐Yes ☐No
Hypertension (high blood pressure)	☐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/Sinus problems	☐Yes ☐No
Other health problems. Please list:	☐Yes ☐No

FAMILY HISTORY: Please place a check below each family member who may have one of the diseases below. Unknown? ☐Yes

	Mental Health	**Asthma**	**Cancer**	**Diabetes**	**Heart Disease**	**High Cholesterol**	**High Blood Pressure**	**Seizures**	**Sickle Cell**	**Thyroid Disease**
Mother										
Father										
Sister										
Brother										
Grand-mother										
Grand-father										
Other:										

PLEASE TURN OVER →

Patient Name: _____ **Date of Birth:** _____

I consent to all of the following:

- The above named patient may receive all available medical and behavioral health services provided at your HFHS SBCHP location.
- Tele-health services, available at specific sites provide your child an opportunity to receive services by a licensed health care provider when a provider is not on site.
- The SBCHP, my child's school and my child's health care provider may exchange health care information and school records for the purpose of continuity and coordination of care.
- The SBCHP may release information regarding treatment to insurance companies or others for the purpose of receiving payment for services.
- If my child is found to need prescription medication at the time of the clinic visit, I give permission for him/her to transport the medication unsupervised from school to home.

By completing and signing this form, I am saying that I am the guardian of the student named above who is under the age of 18; or I am the patient named above and 18 or older. I also understand that if my child is currently in elementary, middle or high school, that this consent will remain valid until my child changes schools or graduates. If your child's new school is affiliated with our program, you will be asked to complete a new consent at that time. I understand that I may cancel my consent for services by giving written notice to SBCHP at any time.

I acknowledge receiving a copy of the Henry Ford Health System Notice of Privacy Practices.

_____

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

I consent for the staff of the SBCHP to obtain a copy of the above named patient's immunization record from the patient's school office, primary care provider's office, local health department and/or MCIR (Michigan Care Improvement Registry). If the records show that my child needs any immunizations, as recommended by the Center for Disease Control and the American Academy of Pediatrics, I agree that all can be given at the SBCHP location. I understand that a form explaining any shots my child needs along with specific vaccine information sheets (VIS) will be sent home prior to the vaccine being given. If I decide that I do not want a shot(s) to be given to my child then I must sign and return the form to the school within the following week.

_____

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

If the HFHS SBCHP has taken photos/videos that include my child, they may be used to promote the health center and healthy activities through various print and internet media, including the Children's Health Fund.

_____

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

If an urgent but non-emergency health care related issue comes up on a day that the medical provider is at a different location and you are unable to come to the school (due to work or transportation reasons), your signature below authorizes us to provide tele-health provider services (if available) or transport your child to receive the necessary care. Your child will be chaperoned (by school personnel, school nurse or a Henry Ford Health System employee) to the provider location (mobile medical unit or fixed health center). We will contact you prior to transportation. Once the evaluation is complete, we will notify you of our findings and whether your child is ok to return to school or needs to go home. Please note that transportation for emergency care does not require your consent. If any emergency situation arises while your child is in our care, we will first call EMS and then immediately notify you.

_____

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

Please complete both sides of this form and return to:
Henry Ford School-Based and Community Health Program. Thank you.

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2017

THIS NOTICE OF PRIVACY PRACTICES (Notice) DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO SUCH MEDICAL INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO PRIVACY

You have entrusted Henry Ford Health System with the responsibility of providing health care for you and your family. We are dedicated to maintaining your trust. We know that the privacy of your medical information is important to you. That's why we take our responsibility to protect the privacy of your medical information very seriously.

This Notice describes how we protect your privacy as we provide services to you. It describes the medical information we collect about you, how we use it, and with whom we share it. This Notice also explains your rights and certain obligations we have regarding the use and disclosure of your medical information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that provides protection for the privacy and security of medical information also known as protected health information (PHI). There are also other federal and state of Michigan laws and regulations that require medical information to be kept private and secured.

We are required by HIPAA to make sure that medical information that identifies you is kept private, give you this Notice explaining your rights and our privacy obligations and privacy practices concerning your medical information, and to follow the terms of the Notice that is currently in effect.

WHO WILL FOLLOW THIS NOTICE

Henry Ford Health System (HFHS) participates with its affiliates and other health care providers and organizations (Members) to perform treatment, payment, health care operations and jointly participate in various quality improvement, population health management and multiparty assessments activities as an organized health care arrangement (OHCA). This Notice applies to all OHCA Members who work jointly with various providers and facilities as well as the HFHS insurance division and its affiliates, to accomplish many goals, which include improving the quality and efficient delivery of your health care and participating in various quality measure programs. Please be mindful that your private doctor may have different notices and policies about the use and disclosure of your medical information created in his or her office or clinic.

By participating in this HFHS OHCA, OCHA Members who may be separate legal organizations can use and disclose PHI with each other to carry out the common purpose of providing you with excellent care, treatment and services, obtaining payment for those services and carrying out health care operations relating to our common purpose, unless the use or disclosure is not allowed by law.

Additionally, HFHS OHCA Members may contract with other trusted third parties (Business Associates) to assist with providing treatment, or obtaining payment or performing healthcare operational activities. When this happens, the Member is required to enter a Business Associate Agreement (BAA) with the Business Associate which requires the Business Associate to limit its use or further disclosure of your PHI to only those purposes allowed under state or federal law and requiring it to protect the privacy and security of your PHI at all times.

COMPLAINTS

If you have any questions about this Notice, or questions or complaints about the handling of your medical information, you may contact the Information Privacy & Security Office in writing, using the information below.

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2017

You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. Under no circumstances will you be retaliated against for filing a complaint.

Henry Ford Health System
Information Privacy & Security Office
One Ford Place, Suite 2A
Detroit, Michigan 48202

(888) 434-3044

MyComplianceReport.com
(Access Code: HFH)

CHANGES TO OUR NOTICE

We may change our Notice from time to time. The changes will apply to all medical information about you that we have at the time of the change, and to all medical information about you that we keep in the future. Generally, the changes will take effect when they appear in a revised Notice. A copy of our current Notice will be posted in our facilities and will be available to all patients.

OUR USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

Each time you receive services from a HFHS hospital, physician or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment and a plan for future care or treatment. This information is often referred to as your health or 'Medical Record'. This information, linked with your name or other identifying information is used in many ways such as providing care, obtaining payment for your care and for running our business. In addition, we may maintain PHI about employer sponsored health and wellness services provided to you, including services provided at your employment site. We will use the PHI to provide you medical treatment or services and will disclose the information about you to others who provide you medical care.

Uses and disclosures of your medical information for purposes described in this Notice may be made in writing, orally, electronically, or by facsimile.

Our use and disclosure of your medical information must comply with both Michigan and federal privacy laws regulations. There are also Michigan and federal laws and regulations that place additional restrictions on the use and disclosure of certain types of medical information, including medical information about mental health, substance abuse, HIV/AIDS conditions, and certain genetic information.

For example, in most cases your written consent is needed before using or disclosing psychotherapy notes (if recorded or maintained by us), documents related to your use of Suboxone, sending you marketing information about 3rd party products or services for which we are receiving direct or indirect payment, or the sale of medical information about you, unless it is otherwise allowed by law. Your consent can always be revoked in writing, but it will not apply to any uses or disclosures that were made before you revoked your consent.

GENERAL USE & DISCLOSURES THAT DO NOT REQUIRE WRITTEN CONSENT

As permitted by HIPAA, we may generally use or disclose your medical information without obtaining prior written consent from you to carry out the activities detailed below:

Treatment: We may use and disclose your medical information to provide you with medical care and any related services in our facilities or in your home. We may also share your medical information with others who provide care to you such as hospitals, hospices, nursing homes, doctors, nurses, physician assistants, residents, medical and nursing students, therapists, technicians, spiritual care providers, nutrition staff,

volunteers, emergency service and transportation providers, medical equipment providers, pharmacies, and others involved in your care that may not be listed. In addition, different hospital departments may use or disclose your medical information to assist with filling your prescriptions, requesting lab work and x-rays along with other medical needs that may not be listed.

Payment: We may use and disclose your medical information as needed to get paid for the medical care that we provide to you or to assist others who care for you to get paid for that care. For example, we may share your medical information with a billing company or with your health insurance plan to obtain prior approval for your care or to make sure your plan will cover your care. You do have the right to request information to be withheld from your insurance company or third party payor if you make a request in writing about a specific treatment or service in advance, and you pay for the services in full before we provide the specific treatment or service to you at any of our facilities.

Health Care Operations: We may use or disclose your medical information for our quality assurance activities and as needed to run our health care facilities. We also may use or disclose your medical information to get legal, auditing, accounting and other services and for teaching, business management and planning purposes. We may use your medical information in combination with other patients' medical information to compare our efforts and to learn where we can improve our care and services. We may disclose your medical information to businesses and individuals who perform services for us as long as they agree to protect the privacy of that information.

OTHER USE & DISCLOSURES THAT DO NOT REQUIRE WRITTEN CONSENT

As permitted by HIPAA, we may use or disclose your medical information without obtaining prior written consent from you to carry out the activities listed below:

Appointments Reminders: We may use your medical information to contact you about upcoming appointments by regular mail, text message, email and telephone.

On-Site Contacts: While you are in our facilities, we may call your name when the doctor or other provider is ready to see you. We may need to contact you by overhead paging or we may ask you to write your name on a sign-in sheet. In these instances, we will take reasonable precautions to protect your privacy.

Patient Reunions: We may hold reunions for various patient groups to celebrate their success in treatment. If you are or were part of such a patient group, we may use your medical information to invite you.

Treatment Alternatives, Health Benefits, Fundraising, and Marketing: We may use and disclose your medical information to contact you about treatment alternatives, health-related benefits, products or services or to provide gifts of nominal value to you or your family. We may also contact you to raise funds for Henry Ford Health System or any of its subsidiaries or affiliates.

Research: Under certain circumstances, we may use or disclose medical information about you, for research purposes. However, all research projects are closely monitored by an Internal Review Board (IRB) whose job is to protect the people (patients) participating in the research project, including the privacy and security of their medical information. Each research project must be cleared through a special IRB approval process before any medical information is disclosed to researchers. Except in very limited circumstances, researchers must then obtain your written authorization before using or disclosing your medical information for their research. Researchers must also ensure that your medical information is kept private and secure. In limited circumstances, researchers may also be allowed access to your health information if the information is limited to medical information accessed in preparation for conducting research (e.g., looking at medical records for patients who have a specific medical condition for research to find a cure), the information being reviewed

relates to the research, and none of the medical information used in the preparation of research leaves the institution.

To Avert a Serious Threat to Health and Safety: We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of another person.

Community/public health activities and reports: We may use and disclose medical information about you to public health federal, state or local agencies regarding disease control, abuse or neglect, and health and vital statistics.

Administrative oversight: We may use and disclose medical information about you related to activities such as accreditations, audits, investigations, licensure, or determining cause of death.

Law enforcement and legal mandates: We may disclose medical information about you to law enforcement officials as allowed by law, such as to comply with warrants, subpoenas, or summonses that are issued by a judicial officer or other properly authorized administrative requests or investigative demands. We disclose medical information in the course of any judicial or administrative proceeding, but only when ordered to do so by the court or administrative tribunal.

National Security and Intelligence Activities: We may disclose medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities as authorized by law.

Protective Services for the President of the United States and Others: We may disclose medical information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Workers compensation or other rehabilitative activities: We may disclose medical information about you as required by law or insurers to provide benefits for work-related or victim injuries or illnesses for you.

Organ and tissue donation and transplant reports: We may use and disclose medical information about you as required by law as necessary to facilitate organ or tissue donation and transplant.

Coroners, Medical Examiners, and Funeral Directors: We may release medical information to a coroner, medical examiner or funeral director.

Inmates: We may release medical information about you to the correctional institution or law enforcement official if you are an inmate of a correctional institution or under the custody of a law enforcement official.

USE & DISCLOSURES TO WHICH YOU HAVE THE OPPORTUNITY TO OBJECT

As permitted by HIPAA, you may object to the following use or disclosures of your medical information:

Patient Directory: Unless you object and tell us not to, we will include certain limited information about you in the patient directory while you are a patient at any of our hospitals. This information may include your name, location in the hospital, your general condition as well as your religious affiliation and may also be released to people who ask for you by name.

Individuals Involved in Your Care or Payment for Care: Unless you object and tell us not to, we may disclose medical information about you to a friend or family member who is involved in your medical care or is responsible for paying for your care. Under unique circumstances, if you are an inpatient or in the emergency room we may share limited information with your family or friends about your condition and location. For example, if you are incoherent we may share your medical information with family members or friends to assist in providing quality care during your stay. In addition, we may disclose information about you to an organization

like the Red Cross, the Federal Emergency Management Agency (FEMA) who is assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Media Condition Reports: Unless you object and tell us not to, we may release your medical information for an update to the media if the media requests information about you using your full name. The following information may be disclosed: your condition described in general terms such as "good", "fair", "serious", or "critical". You have the right to request that this information not be released.

Spiritual Care: Unless you object and tell us not to, to carry our comprehensive care to our patients, we may disclose your medical information to chaplains or other spiritual care providers.

SHARED MEDICAL RECORD/HEALTH INFORMATION EXCHANGES (HIE) INCLUDING CARE EVERYWHERE® AND JACKSON COMMUNITY MEDICAL RECORD

As a part of our business operations, we automatically keep medical information about you in a community wide or shared electronic medical record system that allows HFHS facilities, providers and your primary care physician (if he or she participate in an HIE), the ability to receive copies of all treatment records, emergency records, laboratory, radiology and other test results, even if he or she did not order the test or treatment. We may also participate in various electronic HIEs that help other health care providers who provide you with care to access your medical information when needed. Unless you object and tell us not to, your medical information will be available to other HIEs such as Care Everywhere®, Jackson Community Medical Record (JCMR), or other providers who use EPIC software to create and maintain their electronic health record system. For example, if you are admitted on an emergency basis to a Hospital or facility unrelated to HFHS which participates in the same shared HIE medical record system that HFHS does including JCMR or Care Everywhere®, your medical information will be available electronically to those who need it to treat you. If you wish to opt-out of having your medical information included in an HIE, you have the right to request to do so in writing. If after choosing to opt-out you wish to opt-back-in, you may also do so in writing.

YOUR RIGHT TO OPT-OUT OF CERTAIN ACTIVITIES

Opt-Out Options: We may use and disclose your medical information in a HIE, when raising funds or conducting marketing campaigns as described in the sections above. In regard to fundraising, HFHS or our OHCA Members may participate in these activities and we ask that you aid us in our efforts, while being confident that we are protecting your medical information. If you wish to opt-out of any of these activities, you have the right to request to do so in writing. If after choosing to opt-out you wish to opt-back-in, you may also do so in writing.

YOUR INDIVIDUAL RIGHTS RELATED TO YOUR MEDICAL INFORMATION

You have specific 'rights' related to your medical information. Information about these rights and how you can exercise your rights are included below:

Access and Copies: You have the right to review, inspect or receive a copy of the medical information that we keep about you or anyone else that you have legal authorization to access medical information about. Please note that we may charge you for our costs related to your request. We may deny your request in very limited circumstances. For example, your request may be denied if a licensed health care professional determines, in his/her best professional judgment, that access to the requested information is reasonably likely to cause harm to you or another person or is reasonably likely to endanger the life or physical safety of the individual or another person. If you are denied, you may request that the denial be reviewed and a licensed health care professional will be chosen by us to review the request and denial. Some of our facilities maintain records for a 10-year period and in some instances your medical information may not be available due to our retention policy.

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2017

Disclosure List: You have the right to receive a list of your medical information disclosures, except for disclosures related to treatment, payment or healthcare operations that do not require your consent. You may submit a written request for a time-period up to six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for additional requests.

Amendments: You have the right to submit a written request to amend your medical information, if you believe that information in your medical record is incorrect or that information is missing. We may deny the request if it is not in writing or if it does not include a reason to support the request. In addition, your request may be denied if our information is complete and accurate, if the medical information was not created by us, if the information is not part of the medical information kept by or for us, or is not part of the information that you would be permitted to inspect and copy under certain circumstances. We cannot remove or change the information in the record. If your request is granted, we will add in the supplemental information by an addendum.

Restrictions: You have the right to submit a written request to restrict how we use or disclose your medical information. We will send you a written response informing you about our ability to honor your request. For example, if you pay for a specific service in full completely out of pocket before you receive the service and ask us not to disclose information about that service to your insurance company, we will abide by your request.

Confidentiality: You have the right to request that your medical information be shared with you in a confidential manner, such as at work rather than at home. If you request for us to email your medical information to you, we will do so securely unless otherwise authorized by you or your legal designee.

Copies of our Notice: You have a right to receive a copy of our current Notice. If this Notice was previously sent to you electronically, you may request a paper copy at any time.

Notification of a Breach: You have a right to be notified in writing if there is a breach in the privacy or security affecting your medical information.

EXERCISING YOUR RIGHTS AND OPTING OUT

To exercise any of the rights listed above or to opt-out or object to a specific use or disclosure, please send a written request to our Information Privacy & Security Office. To help with your request you can download or receive the appropriate form(s) by:

- Visiting https://www.henryford.com/-/media/files/henry-ford/patients-visitors/opt-out-form
- Or, if you do not have access to a computer, call our Integrity Line at (888) 434-3044 and request that the correct form be mailed to you.

Completed forms can be submitted via:

- **Mail:** Information Privacy & Security Office, 1 Ford Place, Suite 2A, Detroit, MI 48202
- **Email:** IPSO@hfhs.org
- **Fax:** (313) 874-9449

WHO TO CONTACT

If you have questions related to the organized healthcare arrangement or information detailed in this Notice, please contact the Information Privacy & Security Office at ipso@hfhs.org or by calling (313) 874-9561.

Henry Ford Health System

Date: _____
MRN (or Date of Birth): _____
Name: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge receiving a copy of the Henry Ford Health System Notice of Privacy Practices.

_____
Signature or initials of patient or authorized representative*

_____
Printed name of authorized representative (if applicable)

*Authorized representatives include:

- Parent of Minor
- Legal Guardian
- Personal Representative
- Person under a durable medical Power of Attorney (POA)

For Legal Guardian, Personal Representative or person with authority under a durable medical power of attorney, a copy of appropriate documentation may be necessary.

FOR HFHS USE ONLY

For Workforce Member Use Only

Document Good Faith Effort:
☐ Offered Notice & Acknowledgement to Patient or Representative
☐ Offered to secure an interpreter to present Notice and Acknowledgement to Patient or Representative
☐ Other: _____

If good faith effort is unsuccessful and Acknowledgement is not obtained, document your efforts and reason why the acknowledgement was not obtained:

Reason Acknowledgement was not obtained:
☐ Patient Unable to Sign/Notice Given to Caregiver
☐ Incapacitated Patient/No Patient Representative Present/Emergency Treatment
☐ Patient/Representative Declined to Receive Notice
☐ Patient/Representative Declined Interpreter
☐ Other: _____

Workforce Member Signature: _____

Date of attempt to obtain Acknowledgement: _____

Upon completion scan or file in the patient's record. If form needs to be emailed or faxed, please do so at IPSO@hfhs.org or (313) 874-9449. If form needs to be mailed, please send it to Information Privacy & Security Office, 1 Ford Place, Suite 2A, Detroit, MI 48202.