Beaumont

BEAUMONT SCHOOL WELLNESS PROGRAM CONSENT TO TREATMENT

Beaumont School Wellness Program
11211 Beech Daly Road
Taylor, MI 48180
734.946.3082

Student Name _____ **Birthdate** _____

Section 1: The Beaumont School Wellness Program provides a wide range of medical care, mental health care, and health education services to adolescents, including, but not limited to, the following: sick care, first aid, immunizations, nutrition care, vision screenings, reproductive health education and referral and substance abuse prevention, assessment and referral. In addition, the registered nurse of the Beaumont School Wellness Program may administer the following medications: antibiotic ointment, Silvadene, Acetaminophen (Tylenol) 650 mg, Ibuprofen (Motrin) 400 mg, Claritin 10 mg, cough drops, chewable antacid tablets, saline eye drops, and saline nasal spray. Services are rendered without regard to sex, race, religion, or sexual orientation.

I understand that Michigan law does not require a parent consent for a minor to receive advice or treatment of drug abuse, alcoholism, pregnancy or prenatal care, sexually transmitted diseases, including HIV, reproductive health care, or outpatient counseling. At the health provider's discretion, a parent may be notified if the situation is dangerous or life threatening.

I consent to allow the Beaumont School Wellness Program to provide treatment, including, but not limited to, the services listed above as the wellness center staff consider necessary. If a service is provided through telehealth, including live two-way video, audio, or other computer-based services, I agree that I have read and understand the important information on privacy and possible risks in the attached Telehealth Information document. I understand that I can withdraw my consent at any time by giving notice in writing. If I am signing as a parent/guardian, this consent is valid until the patient turns age 18 years, unless it is withdrawn.

Section 2: *Immunizations and Vaccinations.* I understand my child's immunization records from the Michigan Care Improvement Registry will be reviewed. If it is determined that my child qualifies for the Vaccines for Children program and needs a vaccination, I give my permission for it to be given at the Beaumont School Wellness Program. I understand a letter with the needed shot(s) and the vaccine information sheet(s) will be sent home for my review before the immunization(s) is administered. The required vaccines include Dtap/TD/DT/Tdap, IPV (polio), Hepatitis B, Meningococcal, Measles, Mumps, Rubella (MMR), and Varicella (Chicken Pox). The recommended shots include: Hepatitis A, HPV (Gardisil), Influenza (Flu), and Meningococcal B.
I understand that I can withdraw my consent for immunizations at any time by contacting the clinic.

☐ Yes, I agree. ☐ No, I do not agree. Please Initial _____

Section 3: *Authorization to Pay Insurance Benefits to the Beaumont Teen Health Centers and Release of Information.* I authorize my insurance carrier to pay the Beaumont School Wellness Program for services rendered to me/my child that are covered under my health insurance plan. I understand I may be responsible for fees and charges if my health care provider does not participate in my health insurance plan. I understand I may be responsible for fees and charges that are co-pays, deductibles, or that are for services that are not covered under my health insurance plan. I also authorize the Beaumont School Wellness Program to release medical information to any Beaumont Health hospital, facility, entity or physician, or my/my child's primary health care provider or the for continuity of care. A copy of this authorization may be used in place of the original. I understand that I or my insurance carrier may withdraw this authorization at any time by stating so in writing. I understand that the Beaumont School Wellness Program will protect the information in my/my child's medical record, but from time to time the Beaumont School Wellness Program must release information regarding the care provided to state or federal regulators. I understand that if a test for certain sexually transmitted infections is positive, the law requires the reporting of the positive result to a public health agency.

I have received a copy of the Beaumont Health Notice of Privacy Practices. I understand that this Notice provides me with information on my privacy rights and how my health information may be used and disclosed.

I consent for treatment as stated in above Sections 1, 2 and 3.

Patient/Parent/Guardian Name (please print) _____

Patient/Parent/Guardian Signature _____ **Date/Time** _____

Phone number(s) _____ **Email** _____

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PATIENT INFORMATION

Patient Name_____ **Birth Date** _____

Address_____ **Patient Phone** _____
Street City State Zip

Parent/Guardian Name_____ **Parent/Guardian Birth Date**_____

Parent/Guardian Phone # _____

Emergency Contact Name/Relation/Phone _____

Insurance Name: _____ **ID Number**: _____

Subscriber Name: _____ **Subscriber DOB**: _____

☐ I do not have medical insurance. ☐ Check here if you want us to contact you for Medicaid assistance

Race: ☐ White ☐ Black ☐ Multi-racial ☐ American Indian ☐ Asian/Pacific Islander ☐ Other
Ethnicity: ☐ Hispanic ☐ Arabic ☐ Other
Sex Assigned at birth: ☐ Female ☐ Male ☐ Intersex
Gender Identity: ☐ Male ☐ Female ☐ Third Gender/Non-binary ☐ Prefer to self-describe ☐ Prefer not to say
Preferred Language: ☐ English ☐ Spanish ☐ Arabic ☐ Other_____ **Deaf** ☐ Yes ☐ No **Blind** ☐ Yes ☐ No
Barriers to Learning: ☐ None ☐ Vision ☐ Hearing ☐ Reading ☐ Cognitive: _____ ☐ Other:_____

Medical Information

Current Allergies _____

Current Medications _____

Doctor Name _____ **Phone number** _____

Dentist Name _____ **Phone number** _____

Does the patient have any of the following? Please Circle YES or NO

Asthma	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No
Food Allergy	☐ Yes	☐ No	Emergency plan at school?	☐ Yes	☐ No

List any other medical illness (past/present), surgeries or hospitalizations: _____

_____

Eyes ☐ Glasses ☐ Contact Lenses Date of last eye exam _____

*** TURN OVER*** MUST COMPLETE BOTH SIDES ***