Harbor Beach Community Hospital- Ubly Student Health Center Parent/Guardian Consent Form

The goal of the Ubly Student Health Center is to meet the social and emotional health needs of students to improve their learning. Our services support family values and relationships as much as possible.

SERVICES: Harbor Beach Community Hospital's Ubly Student Health Center provides the following:

➤ Group & Individual Counseling ➤ Referrals to other agencies ➤ Health Education ➤ Help applying for health insurance Services **not provided** at the Student Health Center include: Substance abuse counseling or intensive psychotherapy

If a signed consent form is on file, your child will be able to receive the services listed below. By law and center policy, your child will not receive these services without consent to the extent permitted by law. If you have questions about the following services, please contact Trish VanNorman, Center Director at 989-712-0203. Check yes if you would like your child to receive these services if they are needed. Yes No Social/Emotional Health Counseling (i.e. bullying, anger/stress management, depression, friendship skills, etc.) I have reviewed and understand the services offered by Harbor Beach Community Hospital's Ubly Student Health Center. I give consent for my child to receive the services indicated on this document. By signing this consent form, I certify that I am the legal guardian and legal custodian of Child's Name Grade This consent form will be considered active until such time as I withdraw my consent in writing. I understand I may withdraw my consent for service upon written notice to my child's school at any time. I understand that minor children without a signed consent form on file will not be seen. Exceptions to this include a verbal consent by phone from parent twice per calendar year; an emergency threatening the life of the child or others; students who are legally emancipated, legally married, under court-order, or members of the armed forces. I further authorize the Student Health Center to release information regarding treatment to other medical or mental health providers when needed for coordination of care; to school staff when needed to coordinate services at school; and third party payers to bill when needed for payment of services rendered. I understand that the center will follow state laws that allow minors to obtain specific services. The center will make referrals for mental health, substance abuse, family planning, and child abuse as outlined in state laws. It is the responsibility of the student or parent/guardian to follow-up with referrals and to pay for those re	PARENTAL/GUARDIAN CONSENT
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(Please turn over and complete)

<u>Medical History Form--- To Be Completed By Parent/Guardian</u> If your child or family has a change in health that impacts **any** of the information on this form, please notify us. We will

provide you with a new form. Student Name:					Gender:	M 1	F
First Birthdate://_	_ Gra	Middle ide:	Last Today's Date:				_
Address:							
Street Race: □ White □ Asian □ Blac	k/African /	City American □ Native Ha		State lander □ Am. Ind	Zip ian or Native	Alaskan	
Ethnicity: Hispanic or Latino							
County of Residence: Huro							
Parent/Guardian Name:			Phone Number (s	s):			
	Phone Number (s):						
Parent/Guardian Email:				,			
Additional Student/Child Emer	gency Cor	<u>itacts</u>					
#1			relatio			-	
#2		Phone	relatio	nship to student			-
Do you have a family doctor or classificate if the child has an Bipolar disorder Headaches/migraines Attention Deficit/Hyperactivity D	inic?	•	nd phone #NoNo		ms	□Yes □I □Yes □N substance □Yes □I	No
Do you have any mental health co							_
* Medical/Health Insurance: Insurance Carrier/Name:			ate Insurance				
Policy Number							_
Policy Holder Name	Policy Holder DOB						
Policy Holder Address			-				
Street			City	State		Zip	-
Policy Holder's Employer							_

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