Enroll Your Student at:

Health Delivery's School-Based Health Centers

Located at: **Arthur Hill High School**

Services Ages 10-21

Open Monday-Friday
8:00-3:00 PM

Services

- Physicals (Sports & School)
- Treatment for Illness or Injuries
- Health Education
- Counseling
- Vaccines (Shots)

TB TEST
LAB TEST
DENTAL BUS
MEDICAID ENROLLMENT
AND MUCH MORE!!

Do You Need Health Insurance?

The School-Based Health Center staff is available to enroll families in Medicaid, Food Assistance & Cash Assistance.

Note: No birth control pills, condoms, or devices are prescribed; No abortion counseling or referrals

To Make Your Appointment Call:

ARTHUR HILL HIGH SCHOOL
989-399-5940

For after-hours Medical Care
please call: 989-755-0316

Date of student's last physical:
(Month) / (Day) / (Year)

Great Lakes Bay Health Centers
School-Based Health Center

PARENT/GUARDIAN CONSENT FORM

(Please print clearly and complete the ENTIRE form, front & back)

Student Name	Date of Birth	Age	Gender	Grade	School

Race /Ethnicity (Optional) – Please check ALL that apply.

❒ African American ❒ Caucasian ❒ Hispanic ❒ Asian ❒ American Indian ❒ Middle Eastern

❒ Multiracial (Please Specify)_____ ❒ Other (Please Specify):_____

Address	City	Zip Code	Home Telephone #

Parent/Guardian: Last Name	First Name	M.I.	Date of Birth:	Relationship:

Daytime Telephone #	Work Telephone #	Cell Phone #

Name Of Emergency Contact	Relationship	Telephone #

Name of Student's Physician/Clinic	Telephone #

Name of Student's Dentist	Telephone #

Insurance

❒ Medicaid ❒ Blue Cross/Blue Shield ❒ Health Plus ❒ MIChild/Healthy Kids ❒ Community Choice

❒Great Lakes ❒Molina ❒ McLaren ❒Other: _____

I.D. #	Policy #	Group #	Coverage Code

Policy Owner's Name	Policy Owner's Date of Birth	Social Security #	Relationship To Student

Policy Owner's Employer	Employer's Address

The School-Based Health Center through Great Lakes By Health Centers offers health care services **to students ages 10 to 21**. I give my consent for the above named student to receive all services **including dental services** (listed on the back of this consent form) provided by the School-Based Health Center. By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I understand that I may withdraw my consent for services upon written notice to the Health Center at any time. I authorize the Health Center to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both the Health Center and my child's primary care physician to exchange health care information for the purpose of continuity and coordination of care.

Students may also receive confidential services (mental health counseling, sexually transmitted diseases diagnoses and treatment and pregnancy testing) without parental consent in accordance with Michigan Laws for Minors. Health Center authorization to obtain a copy of the above named student's immunization record from the school's office, primary care provider's office, the Saginaw County Public Health Department, or the Michigan Care Improvement Registry (MCIR). I understand that if I wish to opt-out I will need to inform the School-Based Health Center in writing.

I understand that the School-Based Health Center may need to exchange information with the School Administration regarding communicable diseases that would be easily contagious to other students and life-threatening situations to the student.

I acknowledge receiving a copy of the Great Lakes Bay Health Centers Notice of Privacy Practices brochure.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE:_____

(or student if 18 and older)

Printed Name Of Parent/Guardian:_____

The School-Based Health Center, along with the Centers for Disease Control (CDC), advises you that your child should receive the following vaccinations:

Hepatitis A; Hepatitis B; Diphtheria, Tetanus, Acellular Pertussis (TdaP); Diphtheria, Tetanus(DT or Td); Haemophilus influenza type B (Hib); Pneumococcal vaccine (PCV 7/PPV 23); Measles, Mumps, Rubella (MMR); Varicella (Chicken Pox); Meningococcal (Meningitis); Gardasil (HPV); Polio (IPV); Influenza (Flu)

I understand that the purpose of the recommended vaccination is to prevent the communicable diseases that once killed or harmed infants, children, and adults. Unvaccinated persons are at risk of contracting these preventable diseases and passing them to others. Contracting vaccine preventable diseases results in the loss of school and work time, and may result in the cost of doctor appointments, hospitalizations or premature death. I also understand that any vaccines administered are recorded in the (MCIR).

Please Initial ONE in each Section Below:

Vaccination Consent:	**Dental Treatment Consent:**
☐ **I give permission** to have my child receive the recommended vaccinations.	☐ **I give permission** to have my child receive Dental treatment from Health Delivery School-Based Program
☐ **I would NOT** like my child to be vaccinated and I accept the sole responsibility for consequences as a result of my child not being vaccinated.	☐ **I would NOT** like my child to receive dental treatment from Health Delivery School-Based Program

STUDENT MEDICAL HISTORY: Please check Yes or No.

Acne (Severe)	❒Yes ❒No	Hypertension (high blood pressure)	❒Yes ❒No
ADD / ADHD	❒Yes ❒No	Kidney Disease	❒Yes ❒No
Allergies, i.e. hay fever, dust, pollen,	❒Yes ❒No	Mental/Emotional Disorders	❒Yes ❒No
Allergy: Bee Stings	❒Yes ❒No	Mononucleosis Virus (Mono)	❒Yes ❒No
Allergies (food) [type: :_____]	❒Yes ❒No	Nosebleeds	❒Yes ❒No
Allergies (medications)	*❒Yes ❒No	Overnight Hospitalizations (why:_____)	❒Yes ❒No
*Please List Medications:		Painful Joints	❒Yes ❒No
Anemia (low iron/blood count)	❒Yes ❒No	Pneumonia	❒Yes ❒No
Asthma	❒Yes ❒No	Pregnancy (#Pregnancies ___) (#deliveries ___)	❒Yes ❒No
Backaches	❒Yes ❒No	Rheumatic Fever	❒Yes ❒No
Bladder problems	❒Yes ❒No	Seizures (epilepsy)	❒Yes ❒No
Blood Transfusion	❒Yes ❒No	Serious Injuries	❒Yes ❒No
Chicken Pox	❒Yes ❒No	Shortness of Breath	❒Yes ❒No
Diabetes (high blood sugar)	❒Yes ❒No	Sickle cell (trait or disease)	❒Yes ❒No
Eating Disorders	❒Yes ❒No	Sleep Problems	❒Yes ❒No
Eczema/Rashes	❒Yes ❒No	Stomach problems	❒Yes ❒No
Fainting	❒Yes ❒No	Surgeries (type:_____)	❒Yes ❒No
Frequent Sore Throats	❒Yes ❒No	Tuberculosis (TB)	❒Yes ❒No
Frequent Urination	❒Yes ❒No	Vision/Hearing Problems	❒Yes ❒No
Head Injuries or Concussion	❒Yes ❒No	Prescription medication(s)	*❒Yes ❒No
Headaches/Migraines	❒Yes ❒No	*Please List Medications:	
Heart problems/Murmur	❒Yes ❒No	Other Medical Conditions:	

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 which relative had them.**

❒ Alcoholism/Addiction	❒ Mental /Emotional Disorders
❒ Asthma/Emphysema/Bronchitis	❒ Migraines
❒ Cancer (type)	❒ Seizures
❒ Death under age 50 (cause:_____)	❒ Sickle Cell Anemia/Blood problems
❒ Diabetes (high blood sugar)	❒ Stroke
❒ Heart Problems	❒ Thyroid Problems
❒ High Blood Pressure	❒ Tuberculosis (TB)
❒ High Cholesterol	❒ Other:
❒ Kidney Disease	

PLEASE RETURN FORM TO THE SCHOOL-BASED HEALTH CENTER:

Services Provided: Physicals (sports & school); Treatment for illness or injuries; Health Education; Vaccines (shots); TB Tests; Lab Tests; Dental Services; Behavioral Health Counseling; Medicaid Enrollment; and MUCH MORE!

School-Based Income Verification Form

Patient Name_____ D.O.B._____

Head of Household if other than patient_____ Date of Application: _____

Address: _____

Income Information:

Income $_____ ( ) weekly ( ) biweekly ( ) monthly ( ) annual
How many people does this income support? _____

To be completed by HDI Employee only

FPL% _____

Patient Refused ☐
Pt. Int. _____
Emp. Int.

Application for Sliding Fee Program

Total Annual Household Income from all Sources: $_____
(Including Wages, Social Security, Public Assistance, Unemployment, Pension Payments, Alimony, Child Support or Other Cash Income)

All Persons Residing in Household	Age
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
Total Number of People in Household	_____

To Be Completed by Staff
HDI Sliding Fee Category_____
Proof of Income Verified by HDI Staff
Initials: _____ Date:
_____

I declare that this information relative to my total household income and family size as stated above is true and factual.

X _____
Head of Household/Authorized Person **Date**

Great Lakes Bay Health Centers

School-Based Dental Bus Program

Date of student's last Dental Visit:
_____/_____/_____
(Month) (Day) (Year)

PARENT/GUARDIAN DENTAL CONSENT FORM:

Student Name	Date of Birth	Age	Gender	Grade	School

Parent/Guardian: Last Name	First Name	M.I.	Date of Birth:	Relationship:

Home Telephone #	Work Telephone #	Cell Phone #

Great Lakes Bay Health Center's Mobile Dental Program provides services to the **School-Based Health Center** patients twice each school year.

The following services will be provided:

- ❖ Oral Exam
- ❖ Fluoride Treatment
- ❖ Cleaning
- ❖ Dental Sealants (by age)

A dental report card will be sent home with your child informing you of the treatment they have received, as well as if there are any concerning issues. We encourage you to promptly schedule an appointment with your child's dentist or one of our dental centers if further treatment is necessary. If an emergency arises, please contact 989-754-7771.

- ***If your child has regular cleanings with your family dentist; please check with your dentist before participating in the HDI Mobile Dental Program to avoid duplicate charges.***

If your child has current dental insurance; Great Lakes Bay Health Centers will bill your insurance company. ***Please send a copy of your current insurance card.*** If you do not have insurance, your child may be eligible for a discount, based on household income and family size.

In order to qualify, you must complete the **"Application for Sliding Fee Program"** on the back of this form. .

- Please send a **minimum of $20** with your child. If you do not qualify for the lowest sliding fee discounted rate you will be billed additionally for the remainder of the visit. If you have questions regarding your cost, please call (989) 921-4391.

Great Lakes Bay Health Centers (GLBHC) Mobile Dental Program offers dental services to school-age students. I give my consent for the above named student to receive all services, listed on the front of this consent form, provided by the Mobile Dental Program. By signing this consent form, I certify that I am the legal guardian and legal custodian of the student named above. I understand that I may withdraw my consent for services upon written notice to GLBHC's Dental Department at any time. I authorize GLBHC's Mobile Dental Program to release information regarding treatment to third party payers or others for the purpose of receiving payment for services. I further authorize both GLBHC and my child's dentist to exchange health care information for the purpose of continuity and coordination of care.

Please Initial ONE Below:

I understand that by selecting YES and signing this form, I am consenting to have my child receive a dental exam, cleaning, fluoride, clinical photos and sealants (at the dentist's discretion). I understand that treatment may be obtained at the patient's dental home rather than the mobile dental facility and that obtaining duplicate services at a mobile dental facility may affect benefits that he or she receives from private insurance, a state or federal program, or other third-party provider of dental benefits. I am also aware that if my child has received treatment from their dental home, obtaining duplicate services could affect their dental benefits if also received on the mobile unit. By selecting NO and signing this form, my child will not be treated. **Make sure to read and complete both sides of this form before signing.**

_____ **I Give Permission** to have my child receive dental treatment from GLBHC Mobile Dental Program.

_____ **I Would Not** like my child to receive dental treatment from GLBHC Mobile Dental Program.

✎**SIGNATURE OF PARENT/GUARDIAN**: _____ **DATE**: _____

Printed Name of Parent/Guardian: _____

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CHART #: _____ Exam: _____ Prophy: _____ Sealants: Y / N :_____

LV: SB / W / BS / BP / NS INS: HK / CAID / DELTA / OTHER FPL%_____