Scheurer Wellness Clinic
Parent/Guardian Consent

I give consent for my child to receive services at the Scheurer Wellness Clinic. By signing this consent I certify that I am the legal guardian and legal custodian of the student listed below. I understand I may withdraw my consent at any time with written notice and I understand it is my responsibility to be sure the Scheurer Wellness Clinic has received my withdrawal of consent.

I further authorize the Scheurer Wellness Clinic to release information regarding treatment to other medical or mental health providers when needed for coordination of care. I further authorize both the Scheurer Wellness Clinic and my child's primary care provider to exchange health care information for the purpose of continuity and coordination of care. I give permission to the Scheurer Wellness Clinic to obtain a copy of my child's immunization record from the Michigan Care Improvement Registry (MCIR), the school office or the local health department and record updates as needed.

I understand that as an entity of Scheurer Healthcare Network, the Scheurer Wellness Clinic participates in and recognizes the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or communications by alternative means such as to a cell phone instead of the home phone.

I understand that if anyone involved in my child's care has an exposure to any of my child's blood or other body fluids, a blood or tissue test may be performed on my child without consent to detect the presence of human immunodeficiency virus (HIV) or other communicable diseases.

The Scheurer Wellness Clinic may confirm, for school attendance purposes only, the dates and times that a student was in the clinic. Protected Health Information will not be communicated to school administration.

This consent will be considered active for the entire school year, unless I withdraw my consent in writing. I understand I may withdraw my consent for service upon written notice to the Scheurer Wellness Clinic at any time.

2016-2017 School Year

Student Name:____

Parent/Guardian Signature:_____________________________________

Parental Consent is not required for crisis intervention or emergency care. Emergency care/crisis intervention will be provided, with parental notification to follow.

Scheurer Wellness Clinic

Student Health History
To be completed by parent/guardian

Student Last Name:		**First Name:**		**Middle Initial:**
Date of Birth:	Age:	Male ☐ Female ☐	Grade:	Home Room:
Street/Mailing Address, City, Zip Code:				

Parent/Guardian Last Name:	**First Name:**	Relationship to Student:
Home Phone #	Cell #	Work #
Parent/Guardian Last Name:	**First Name:**	Relationship to Student:
Home Phone #	Cell #	Work #
Name of Emergency Contact:	Relationship to Student:	Phone #:
Pharmacy Preference:	Pharmacy Location:	Pharmacy Phone #:
Preferred method of contact: ☐Phone--❍Home ❍Cell ☐ Written Communication ☐ Other:___________________________________		
Name of Student's Family Dr./NP/PA:		
Date of Student's Last Well Child Exam:	Date of Student's Last Sports Physical:	

Please X the YES column if any of these conditions apply to the student or mark here for ☐ NONE

Condition	Yes	Condition:	Yes	Condition	Yes
Asthma		Epilepsy		Pneumonia	
ADD/ADHD		Fainting		Seizures	
Anemia		Frequent Urination		Shortness of Breath	
Backaches		Heart Problems		Skin Disorder	
Bipolar Disorder		Headaches/Migraines		Sore Throats	
Bladder Problems		High Blood Pressure		Substance Abuse	
Diabetes		Joint Problems		Vision Problems	
Depression		Kidney Disease		**Other Conditions:**	
Eating Disorder		Nosebleeds			
Eczema/rashes		Pounding of Heart			

Indicate any allergies your child has:

Food Allergies:	Medication Allergies:	Environmental Allergies	Other Allergies:

Does the student carry an **Epi-Pen**?	Where is **Epi-Pen** stored?	Has student used the **Epi-Pen** in the past?

Please indicate surgeries or hospitalizations the student has had:

Surgeries:	**Hospitalizations:**

Please list any other concerns you have regarding your child:

Daily Medications: List any medications the student takes *regularly*.

Name of Medication	Dosage	Frequency
1.		
2.		
3.		
4.		

Would you like the clinic to administer any of your child's daily medications?

☐ Yes** ☐No ☐N/A

**Please complete separate Daily Medication Administration form.

The Scheurer Wellness Clinic stocks the following:

Tylenol (Acetaminophen)
Cough Drops
Motrin (Ibuprofen)
Antibiotic Cream
Antacid
Hydrocortisone Cream
Albuterol (nebulizer treatment)
Guiafenesin (cough expectorant)

Check one:

☐ I give permission for my child to take the above medications if indicated per standard clinic treatments.

☐ I give permission to use above medications ***except***:__________________________

☐ Scheurer Wellness Clinic **DOES NOT** have my permission to give any medications to my child.

Sign:

Parent/Guardian Signature:____

Date:____