700 Newberry Avenue, Room 170
Newberry, MI 49868
906-293-3226 ext 1427
www.facebook.com/TheCAMP.TAS

Consent Form

Student Name (Last Name, First Name, M.I.)	Birth Date	Age	Sex	Grade

Address	City	Zip Code	Student Telephone ☐ Please check box if you give THE CAMP permission to text appointment reminders

Race/Ethnicity: □African American □ White □ Hispanic/Latin □ Native American Indian/Alaskan □Asian □Native Hawaiian/Pacific Islander

Parent/Guardian: Last Name	First Name	M.I.	Relationship to Student

Daytime or Work Telephone #	Home Telephone #	Cellular #	Parent Email Address

Name of Emergency Contact	Relationship	Telephone #

Name of Student's Physician/Clinic	Telephone #	Month & Year of Last Well Child/Teen Exam

Name of Student's Dentist	Telephone #	Last Routine Dental Exam

Insurance* **(Please include a copy of the insurance card - front and back; OR bring it in and we will make a copy for you)**

☐Medicaid ☐BCBS ☐NGS Insurance ☐UPHP ☐TRICARE ☐Other _____ ☐No Insurance

Policy/Contract #	Group #	To find out if your family is eligible for LOW-COST or FREE healthcare coverage call toll free 1-888-988-6300. You can also apply online: www.healthcare4mi.com	
Policy Holder Name (Last Name, First Name, M.I.)	Policy Holder Date of Birth		
Address	City	State Zip Code	Relationship to student

As legal parent or guardian I consent to the following statements:

- The above named may receive services at the C.A.M.P. School-Based Health Center for their duration of their time at Tahquamenon Area Schools. Any changes to this consent, including ending the consent, must be submitted in writing to C.A.M.P. staff.
- The C.A.M.P. and my child's primary care provider may exchange health information for continuity of care according to State and Federal laws.
- The C.A.M.P. may obtain information from Tahquamenon Area Schools regarding my child's grades, disciplinary action, and/or school attendance for program evaluation purposes.
- For the safety of my child, C.A.M.P. staff may share with school staff your child's check-in and check-out times at the C.A.M.P.
- My child's medical and/or mental health records may be chosen, at random, as part of the clinical review process. This is required under the C.A.M.P.'s Continued Quality Improvement Plan. Records may be reviewed for quality assurance purposes. Records are only reviewed by the Directing Physician or a peer clinician. All reviewers are bound by the same strict confidentiality and HIPAA regulations as our staff.
- I am under no obligation to have my child use the clinic services.
- The C.A.M.P. may disclose protected health information regarding this visit to other entities for continuation of treatment, payment, and health care operations. If required by law, separate release forms will be used at time of service. Billing information will be shared to the providers of care.
- I have been provided with a copy of the Notice of Privacy Practices and Patient Bill of Rights.
- I understand that no patient will be turned away for lack of insurance.

☐ By checking this box, I allow my student to access mental health services at the C.A.M.P. (all statements above apply to mental health as well).

By signing this consent form, I agree to the above statements. I also certify that I am the parent/legal guardian of the student named above, and am registered with the school as such.

Signature of Parent/Guardian _____ **Date:**_____

- Over

Student Medical History: **Please check yes or no**

Bee sting allergies	☐yes	☐no	Seizures (epilepsy)	☐yes	☐no
Anemia	☐yes	☐no	Stomach problems	☐yes	☐no
Seasonal allergies	☐yes	☐no	Heart problems	☐yes	☐no
Asthma	☐yes	☐no	Bladder problems	☐yes	☐no
Diabetes	☐yes	☐no	Cancer	☐yes	☐no
Eczema/rashes	☐yes	☐no	Headaches/migraines	☐yes	☐no
ADD/ADHD	☐yes	☐no	High blood pressure	☐yes	☐no
Sickle cell disease	☐yes	☐no	Fainting	☐yes	☐no
Pounding of heart	☐yes	☐no	Pneumonia	☐yes	☐no
Shortness of breath	☐yes	☐no	Kidney disease	☐yes	☐no
Frequent urination	☐yes	☐no	Painful joints	☐yes	☐no
Nosebleeds	☐yes	☐no	Backaches	☐yes	☐no
Frequent sore throats	☐yes	☐no	Thyroid disease	☐yes	☐no
Psychological disorder	☐yes	☐no			

Daily Meds: _____
Condition for Meds: _____
Medication Allergies: _____
Food Allergies: _____
Past Surgeries: _____
Hospitalizations: _____
Other health problems: _____

Family Medical History

Check any illnesses that relatives
(ie: mother, father, aunt, uncle, grandparents or sister, brother) has, **Please note which relative has them**

☐ Heart Problems _____	☐ Cancer
☐ Cholesterol	☐ Diabetes (high blood sugar)
☐ High Blood Pressure	☐ Stroke
☐ Asthma/Emphysema/Bronchitis	☐ Seizures
☐ Death under age 50 – Cause:	☐ Kidney or Thyroid Disease
☐ Sickle Cell Anemia/Blood problems	☐ Other

Services provided at The CAMP include:

- Well teen exams & sports physicals
- Immunizations (including flu shots)
- Concussion baseline & post-accident testing
- Nutrition Counseling
-Asthma, diabetes & weight management
- Pregnancy & STI testing
- Acute care for sore throat, ear pain, non-emergent injuries, etc.
- Blood sugar & cholesterol screening
- Counseling services for: Anxiety, depression, anger management, self-esteem, academic concerns, family or relationship issues.

LIMITATION OF SERVICES:

NO family planning, birth control pills or contraception devices will be dispensed or prescribed
NO abortion counseling, referrals or services are provided.

Can we help? Does your family have immediate needs for assistance?

___ **Health Insurance for my child (to find out if your family is eligible for free or low cost insurance call 1-888-988-6300 or visit www.healthcare4mi.com)**
____ **Housing** ____ **Food** **Other:** _____

This information is confidential and will only be shared with appropriate resources with your consent.

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