HEALTH DEPARTMENT of Northwest Michigan
1-800-432-4121

CHILD AND ADOLESCENT HEALTH PROGRAM
Minor Confidential Services Consent

Health center services include: primary care; treatment for illness and injuries; physical exams for school, sports, and camp; basic laboratory services and tests; referral for specialty health services; student health assessment, education, and risk reduction programs; chronic disease management; immunizations; family planning counseling services; sexually transmitted diseases; HIV counseling and testing; medication administration; vision/hearing screenings; dental care; and individual, family and group counseling services.

The health center does not provide abortion counseling, services, or referrals.

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School

Street Address	Mailing Address (PO Box)	City	Zip Code	Home Phone Number

Race (Optional) ❒ White ❒ Black ❒ Asian ❒ American Indian ❒ More Than One ❒ Other

Ethnicity (Optional) ❒ Non-Arabic/Non-Hispanic ❒ Hispanic ❒ Arabic

Mother Last Name	Mother First Name	Father Last Name	Father First Name

Guardian Last Name	Guardian First Name	Relationship To Student

Your Telephone Number	Your Cell Phone	Your E-Mail Address

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

Confidential Services:

Under Michigan law, I understand that minors may without parental consent, receive advice, testing and/or treatment for substance abuse, family planning counseling services; sexually transmitted diseases, HIV, and mental health services, which are defined as Confidential Services.

I further understand that minors above the age of 14 years can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. I understand that the counselor treating me may notify my parent or guardian without my permission if someone is hurting me or I am hurting myself or someone else, or if I have a plan to hurt myself or someone else, or if it is seen to be in my best interest. In those cases, the counselor will try to inform me of their duty to notify my parents before informing them.

If I am seeking information or intervention about one of the confidential services, I understand that I can seek care related to these issues at the Child and Adolescent Health Center.

I have read and understand the above information and sign it freely and voluntarily.

By signing this form I agree to the following:

- **I have reviewed and understand the Confidential Services offered by the health center. I give my consent to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I further authorize the Child and Adolescent Health Center to release information regarding treatment to the following: Health Center staff, its subcontractors, and other health care providers when needed to coordinate care and school staff when needed to coordinate services. I understand I may withdraw my consent for services at any time upon written notice.**
- **I received a copy of the Health Department's *Notice of Privacy Practices* brochure.**
- **I have completed the enclosed *Student and Family Health History* form on the back side of this form.**
- **I understand there will be no charge or billing for this service.**

_____ _____

(DATE) (Printed Name and Birth Date)

_____

(Signature)

_____

(Witness Signature)

Child/Adolescent Name

CLIENT AND FAMILY HISTORY FORM (Please write NA, if nothing to report)

Name of Student's Physician or Clinic	Physician or Clinic Telephone Number	Name of Student's Dentist
Name of Pharmacy		Pharmacy Telephone Number
Allergy (Medicine, food, environment, seasonal)		Reaction/Severity

Medication/Prescription/Vitamins	Dose	Frequency	Route	Who prescribed this medication?	Reason

Last Complete Physical Exam _____ Last Dental Exam _____ Last Eye Exam _____

Disease/Condition	Client	Mother	Father	Sibling	Grand-parent	Other	Comment
Addiction – Type:	☐	☐	☐	☐	☐	☐	
Anemia	☐	☐	☐	☐	☐	☐	
Asthma - Specify	☐	☐	☐	☐	☐	☐	
Autoimmune disorder	☐	☐	☐	☐	☐	☐	
Birth defects	☐	☐	☐	☐	☐	☐	
Blood/Bleeding disorders	☐	☐	☐	☐	☐	☐	
Cancer	☐	☐	☐	☐	☐	☐	
Death Under Age 50 - Cause:	☐	☐	☐	☐	☐	☐	
Developmental Disability	☐	☐	☐	☐	☐	☐	
Diabetes	☐	☐	☐	☐	☐	☐	
Eating disorders/Special diet/Pica	☐	☐	☐	☐	☐	☐	
Endocrine/Thyroid	☐	☐	☐	☐	☐	☐	
Gastrointestinal disorders	☐	☐	☐	☐	☐	☐	
Genetic abnormalities	☐	☐	☐	☐	☐	☐	
Heart disease	☐	☐	☐	☐	☐	☐	
Heart abnormalities/Murmurs	☐	☐	☐	☐	☐	☐	
Hepatitis/Liver disease	☐	☐	☐	☐	☐	☐	
High Cholesterol	☐	☐	☐	☐	☐	☐	
Hypertension	☐	☐	☐	☐	☐	☐	
Kidney/Urinary disease	☐	☐	☐	☐	☐	☐	
Learning Disorder	☐	☐	☐	☐	☐	☐	
Musculoskeletal disorders	☐	☐	☐	☐	☐	☐	
Neurologic disorder/Seizures	☐	☐	☐	☐	☐	☐	
Obesity/Overweight	☐	☐	☐	☐	☐	☐	
Physical/Sexual/Verbal/Domestic Abuse	☐	☐	☐	☐	☐	☐	
Psychiatric disorders/ Depression/Suicide - Specify	☐	☐	☐	☐	☐	☐	
Skin disorder - Specify	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	

Child/Adolescent Name

CLIENT HISTORY – Please check if your child has had/does have any of these conditions.

Condition	Date of Onset	Comment
ADD/ADHD		
Anaphylaxis		
Autism		
Backaches/Back injury		
Fainting		
Frequent sore throat		
Frequent urination/Bladder conditions		
Problems with head, eyes, ears, nose, or throat		
Headaches		
Hearing problems		
Hernias		
Nosebleeds		
Pneumonia		
Problems with childhood vaccines		
Rheumatic Fever		
Shortness of breath		
Other:		
Substance Use/Exposure		
Alcohol		
Chew/Tobacco/Cigarettes/Vaping		
Cocaine		
Marijuana		
Secondhand smoke		
Other:		
Surgery/Hospitalizations		
Adenoids removed		
Appendectomy		
Asthma Exacerbation		
Ear tubes		
Fracture		
Head injury/Concussion		
Heart Surgery		
Premature birth		
Tonsillectomy		
Trauma		
Other:		

Reviewed with client _____ _____
Initials Date

Please return completed form to:

The Child and Adolescent Health Program is operated by the Health Department of Northwest Michigan,
with major funding from the Michigan Department of Health and Human Services and Michigan Department of Education.