RED HAWK WELLNESS CENTER

ASPIRE RURAL HEALTH SYSTEM Thumb Area Psychological Services

Parent/Guardian Consent Form

We want to help your child stay healthy, safe, and ready to learn. The Red Hawk Wellness Center (RHWC) provides physical and emotional health services to students during the school day. Our goal is to partner with families, not replace them.

SERVICES: Red Hawk Wellness Center provides the following:

- ☐ Health education
- ☐ Group & Individual Counseling
- ☐ Help filling out insurance forms.
- ☐ Referrals to other agencies
- ☐ Nursing Services
- ☐ Health and Wellness Screenings

Services **not provided** at the Student Health Center include:

- Dispensing daily prescription medication (continue to follow the policies in your child's school handbook)
- Substance abuse counseling or intensive psychotherapy
- The Center **DOES NOT** dispense, prescribe, or otherwise distribute family planning drugs and /or devices; provide abortion services or referrals for abortion services.

PARENTAL/GUARDIAN CONSENT

Please review the information below and let us know which services you would like your child to be able to use if needed. Your child will only receive services if you give consent- except in emergencies where we will always notify you afterwards. By law and our policy, we need your consent to provide these services. For other services (like Tylenol for a headache), we'll try to contact you by phone or send a note home. If you have any questions about these services, please contact 989-912-1829. We're here to help!

Check yes next to the services you would like your child to receive if needed.

Yes ☐ No ☐ Mental Health Services (i.e. bullying, anger/stress management, depression, friendship skills, etc.).

Yes ☐ No ☐ Nursing Services (i.e. headache, stomach ache, injury, first aid, etc.)

NOTES: The center will follow federal and state laws that allow minors to obtain specific services. In some cases, we may refer your child for additional services such as mental health support, substance use concerns, family planning or sexual health testing, or abuse reporting if required by law. We will always encourage you to be involved, and we are here to help you navigate these services. Following up with a referral and any related costs is the responsibility of the family.

- I understand that this consent form stays active until my child moves or no longer qualifies for services, or I cancel it in writing.
- I give the RHWC permission to share my treatment information with my primary care provider, other health professionals, and school staff as needed to coordinate care and services, following the laws like HIPAA, FERPA, and Michigan laws on minors' rights.
- I understand that I can access the Red Hawk Wellness Center's Notice of Privacy Practices.
- I have read and understand this form. I give permission for my child to receive the services I selected above. I confirm that I am the legal guardian of this student.

Child's Name _____ **Grade** _____ **School** _____

_____ _____

Signature of parent/guardian **Date**

(Please turn over and complete) 

Child's name (Last, first, middle initial)		Date of birth:	
Age:	Gender:	Grade:	Phone Number:
Home Address:	City:	Zip:	
Email address:			
Race/Ethnicity: ☐ Black/African ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Hispanic/Latin ☐ American Indian/Alaskan Native ☐ Asian			
Parent(s)/Guardian(s) Name: ☐		Phone Number:	
Primary Care Provider:		Phone number:	
Insurance: ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Other ☐ Uninsured– (☐ I would like to be contacted regarding Medicaid Enrolment ☐ I would not like to be contacted.)			

Daily Medications: Please list any medications your child takes regularly.

Name of Medicine	Dose (mg)	Frequency	Name of Medicine	Dose (mg)	Frequency
1)			3)		
2)			4)		
Allergies to medications:					

Over-the-counter (OTC) Medications: Please indicate if your child may receive OTC medications as needed.

Name of OTC Medication	Yes	No	Name of OTC Medication	Yes	No	Name of OTC Medication	Yes	No
Acetaminophen (Tylenol)			Cough Drops			Calamine lotion		
Ibuprofen (Motrin)			Triple Antibiotic Ointment			Sunscreen		
Benadryl			Hydrocortisone					
Tum(s) Chewable			Benadryl cream					

Child's Health History: If any of these conditions apply, please x in the Yes column.

Condition:	Yes	Condition:	Yes	Conditions:	Yes	Condition:	yes	Condition:	Yes
Bee sting allergies		Seizure/Epilepsy		ADD/ADHD		Bowel Disorders		Liver problems	
Food allergies		Asthma		High blood pressure		Mental health		Kidney problems	
Seasonal allergies		Diabetes		Fainting		Heart problems		Bleeding disorders	
Do you carry an Epi-Pen		Anemia		Shortness of breath		Stomach problems		Other	

Please explain any other conditions or concerns your child may have_____

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