Ascension Michigan
School Based Health Center

13701 Oak Park Boulevard
Oak Park, MI 48237
Phone: (248) 336-7740
Fax: (248) 336-7758

Dear Parent or Guardian:

Ascension Michigan School Based Health Center and **Oak Park School District** are pleased to provide health services for students at Oak Park High School. Health Center's hours of operation are 7:30 a.m. to 4:00 p.m., Monday – Friday, closed on weekends and holidays.

Our facility is overseen by a **Medical Director** that is a board certified **Family Practice Physician**. A certified **Nurse Practitioner** and a **Registered Medical Assistant** will provide care to Oak Park students. We provide a wide range of services, including physical exams, sick visits, and a variety of school and community educational programs.

Our goal is to improve the physical health of Oak Park High School. All interactions between the health center staff and students will be kept confidential to the extent provided by the law.

We are approved by the Michigan Department of Community Health to bill medical insurance companies for services provided in the Health Center. Claims will be submitted from our office directly to your insurance company for payment. **Parents or Guardians of students will never be responsible for any portion of unpaid balances on these bills**. Please do not discourage your child from visiting the health center because of lack of insurance or problems with bill payment. Health center management will address all billing issues. If you do not have medical insurance, please call 248-336-7740 or stop by the Health Center for help with applying for Healthy Kids or MIChild Insurance.

Attached are the **consent form, medical insurance registration form, immunization consent, and a parent questionnaire**. Please return these completed forms to us as soon as possible. By providing us with up-to-date information about your child's health, it will further help us to better serve the needs of your child.

We look forward to serving you and your child. If you have any questions or would like further information, please call Monday – Friday, between 7:30 a.m. – 4:00 p.m. In case of an emergency during non-business hours, please call 911 or go to the nearest emergency room. For mental health crisis, please contact **Oakland County Crisis Line a 24-hour Resource and Crisis Helpline at (248) 456-0909 / 1-800-231-1127.**

Available Services

Medical:	General health assessment, school/sports physicals, sick care, immunizations, vision, and hearing testing, laboratory screening, health education, and nutrition counseling.
Health Education:	Student and parent educational programs related to the school age child's health issues; i.e. asthma, hypertension, diabetes, nutrition, abstinence, substance abuse prevention, and conflict resolution.

Sincerely,

Ascension Michigan School Based Health Center Staff

Ascension Michigan **PATIENT REGISTRATION FORM**
School Based Health Center

Student/Patient Name: *(last, first, middle)*	Birth Date	Age ☐Male ☐Female	SSN#:

Race (Optional): ☐African American ☐White ☐Native Hawaiian ☐Arab American ☐American Indian/Alaska Native ☐Asian ☐Other Pacific Islander ☐Unreported/Refused to Report

Ethnicity (Optional): ☐Hispanic/Latino ☐Not Hispanic/Latino ☐Arabic

9. Address	10. City	11. Zip Code	12. Home Phone #:

Parental/Legal Guardian Information

Mother's Full Legal Name:	Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address:		Home Phone#: Cell Phone#:		
Employer Name & Address		Employer Phone #:		
Father's Full Legal Name:	Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address:		Home Phone#: Cell Phone#:		
Employer Name & Address		Employer Phone #:		
Legal Guardian Name: *(if not mother or father)*	Date of Birth:	SSN#:	Marital Status: Single Married Widow Divorced	Race
Address		Home Phone#: Cell Phone#:		
Employer Name & Address:		Employer Phone #:		
Emergency Contact Name:	Relationship to Student/Patient:	Telephone #:		
Name of Student's/Patient's Doctor/Clinic:		Telephone #:		
Name of Student's/Patient's Dentist:		Telephone #:		

Insurance: ☐Medicaid ☐Blue Cross Blue Shield ☐HAP ☐Total ☐Midwest ☐Great Lakes ☐Molina ☐Other: _____

Medicaid #:	Is Medicaid your only Insurance? ☐Yes ☐No Name of Other Insurance:			
Primary Insurance Name:	Subscriber Name:			
Group#:	Policy#:			Co-Pay:
Patient Relationship to Subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other	
Secondary Insurance Name:	Subscriber Name:			
Group#:	Policy#:			Co-Pay:
Patient Relationship to Subscriber: ☐ Self	☐ Spouse	☐ Child	☐ Other	

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Consent For Health Services

Name: _____

Birth date: _____

Although crisis intervention and emergency care do not require consent, medical services require a signed consent before services are provided. The following services are available from your **Ascension Michigan School Based Health Center**:

- Physical exams
- Diagnosis and management of acute and chronic illnesses/disease
- Immunizations
- Dental, Vision, and Hearing screenings
- Basic Laboratory tests including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin

- Health education, activity groups, risk prevention counseling
- Counseling and referrals for mental health, physical/sexual abuse, substance abuse*
- Crisis intervention
- Group and Family Counseling
- Referral for resources such as food, shelter, financial issues, transportation

* Current Michigan Law mandates for confidential services to minors in these areas, as well as Pregnancy/STI/HIV testing and counseling.

LIMITATION OF SERVICES

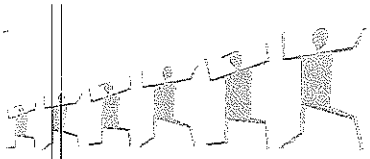
- ***NO*** birth control pills or devices are dispensed or prescribed at ***ANY* Ascension Michigan School Based Health Center/Community Health Center** located on school property.
- ***NO*** abortion counseling, referrals or services are provided at ***ANY* Ascension Michigan School Based Health Center/Community Health Center.**

I consent to all the following:

- I have reviewed and understand the services offered by the **Ascension Michigan School Based Health Center**. I give consent for my child to receive the services indicated on this document. By signing this consent form I certify that I am the legal guardian and legal custodian of: _____.
- I understand this consent will remain valid until my child graduates, and that I may withdraw my consent for services upon written notice to the **Ascension Michigan School Based Health Center** at any time.
- I further authorize the **Ascension Michigan School Based Health Center** to release/exchange information regarding treatment to 1) my child's primary care physician or mental health providers when needed for coordination of care, 2) school staff when needed to coordinate services at school, 3) third party payers or others for the purpose of receiving payment for services. ***However services will be provided regardless of insurance and/or ability to pay.***
- The School-Based and Community Health Program may obtain a copy of the above name student's/patient's immunization record from the student's/patient's school office, primary care provider's office, and/or local health department.
- I understand all Ascension Michigan School Based Health Center's medical records are part of the SJPHS electronic medical records system.
- I understand that testing for bloodborne diseases, including HIV / AIDS, may be performed upon a patient without a separate written consent in the event that a healthcare professional from the Center sustains exposure to blood or bodily fluids from the patient's open wound, percutaneous mucous membrane or occupational hazard.

_____ _____

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



Guidelines for Adolescent Preventive Services
Parent/Guardian Questionnaire

Confidential (Your answers will not be given out.)

Date _____

Adolescent's name _____ Adolescent's birthday _____ Age _____

Parent/Guardian name _____ Relationship to adolescent _____

Your phone number: Home _____ Work _____

Adolescent Health History

1. Is your adolescent allergic to any medicines?
   ☐ Yes ☐ No If yes, what medicines? _____

2. Please provide the following information about medicines your adolescent is taking.

Name of medicine	Reason taken	How long taken

3. Has your adolescent ever been hospitalized overnight?
   ☐ Yes ☐ No If yes, give the age at time of hospitalization and describe the problem.

Age	Problem

4. Has your adolescent ever had any serious injuries?
   ☐ Yes ☐ No If yes, please explain. _____

5. Have there been any changes in your adolescent's health during the past 12 months?
   ☐ Yes ☐ No If yes, please explain. _____

6. Please check (✓) whether your adolescent ever had any of the following health problems:
   If yes, at what age did the problem start:

	Yes	No	Age		Yes	No	Age
ADHD/learning disability	☐	☐		Headaches/migraines	☐	☐	
Allergies/hayfever	☐	☐		Low iron in blood (anemia)	☐	☐	
Asthma	☐	☐		Pneumonia	☐	☐	
Bladder or kidney infections	☐	☐		Rheumatic fever or heart disease	☐	☐	
Blood disorders/sickle cell anemia	☐	☐		Scoliosis (curved spine)	☐	☐	
Cancer	☐	☐		Seizures/epilepsy	☐	☐	
Chicken pox	☐	☐		Severe acne	☐	☐	
Depression	☐	☐		Stomach problems	☐	☐	
Diabetes	☐	☐		Tuberculosis (TB)/lung disease	☐	☐	
Eating disorder	☐	☐		Mononucleosis (mono)	☐	☐	
Emotional disorder	☐	☐		Other: _____	☐	☐	
Hepatitis (liver disease)	☐	☐					

7. Does this office or clinic have an up-to-date record of your adolescent's immunizations (record of "shots")?
   ☐ Yes ☐ No ☐ Not sure

Family History

8. Some health problems are passed from one generation to the next. Have you or any of your adolescent's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems? If the answer is "Yes," please state the age of the person when the problem occurred and his or her relationship to your adolescent.

	Yes	No	Unsure	Age at Onset	Relationship
Allergies/asthma	☐	☐	☐		
Arthritis	☐	☐	☐		
Birth defects	☐	☐	☐		
Blood disorders/sickle cell anemia	☐	☐	☐		

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	Yes	No	Unsure	Age at Onset	Relationship
Cancer (type_____)	☐	☐	☐	_____	_____
Depression	☐	☐	☐	_____	_____
Diabetes	☐	☐	☐	_____	_____
Drinking problem/alcoholism	☐	☐	☐	_____	_____
Drug addiction	☐	☐	☐	_____	_____
Endocrine/gland disease	☐	☐	☐	_____	_____
Heart attack or stroke *before* age 55	☐	☐	☐	_____	_____
Heart attack or stroke *after* age 55	☐	☐	☐	_____	_____
High blood pressure	☐	☐	☐	_____	_____
High cholesterol	☐	☐	☐	_____	_____
Kidney disease	☐	☐	☐	_____	_____
Learning disability	☐	☐	☐	_____	_____
Liver disease	☐	☐	☐	_____	_____
Mental health	☐	☐	☐	_____	_____
Mental retardation	☐	☐	☐	_____	_____
Migraine headaches	☐	☐	☐	_____	_____
Obesity	☐	☐	☐	_____	_____
Seiures/epilepsy	☐	☐	☐	_____	_____
Smoking	☐	☐	☐	_____	_____
Tuberculosis/lung disease	☐	☐	☐	_____	_____

9. With whom does the adolescent live most of the time? *(Check all that apply.)*

☐ Both parents in same household
☐ Mother
☐ Father
☐ Other adult relative
☐ Stepmother
☐ Stepfather
☐ Guardian
☐ Brother(s)/ages _____
☐ Sister(s)/ages _____
☐ Other _____
☐ Alone

10. In the past year, have there been any changes in your family? *(Check all that apply.)*

☐ Marriage
☐ Separation
☐ Divorce
☐ Loss of job
☐ Move to a new neighborhood
☐ A new school or college
☐ Births
☐ Serious illness
☐ Deaths
☐ Other _____

Parental/Guardian Concerns

11. Please review the topics listed below. Check(✓) if you have a concern about your adolescent.

	Concern About My Adolescent		Concern About My Adolescent
Physical problems	☐	Guns/weapons	☐
Physical development	☐	School grades/absences/dropout	☐
Weight	☐	Smoking cigarettes/chewing tobacco	☐
Change of appetite	☐	Drug use	☐
Sleep patterns	☐	Alcohol use	☐
Diet/nutrition	☐	Dating/parties	☐
Amount of physical activity	☐	Sexual behavior	☐
Emotional development	☐	Unprotected sex	☐
Relationships with parents and family	☐	HIV/AIDS	☐
Choice of friends	☐	Sexual transmitted diseases (STDs)	☐
Self image or self worth	☐	Pregnancy	☐
Excessive moodiness or rebellion	☐	Sexual identity (heterosexual/homosexual/bisexual)	☐
Depression	☐	Work or job	☐
Lying, stealing, or vandalism	☐	Other: _____	☐
Violence/gangs	☐		

12. What seems to be the greatest challenge for your teen? _____

13. What is it about your teen that makes you proud of him or her? _____

14. Is there something on your mind that you would like to talk about today?

What is it? _____

15. Can we share your answers to Question 13 with your teen? ☐ Yes ☐ No

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VACCINE PREVENTABLE DISEASE

INFORMATION/CONSENT FORM

CHILD'S NAME: _____ **CHILD'S BIRTHDATE** _____

I _____ have read or had the risks associated with vaccination explained to me. I have had the opportunity to ask
(Parent/guardian name - Print)

questions and feel satisfied with the answers given. I give permission to vaccinate my child _____
(Child's name)

Signature of Parent/Guardian: _____ Date: _____

Chickenpox (Varicella) Chickenpox is a common childhood disease which can be serious. Chickenpox can lead to pneumonia, brain damage, or death. Children who receive the chickenpox vaccination may experience fever, soreness, a mild rash, or swelling where the shot was given. In rare cases a child may experience a seizure (less than 1 out of 1,000 cases). It may be possible for someone who gets a rash from the chicken pox shot to give chickenpox to another person. If the person getting the vaccine has an immune system that is not working properly, or is in close contact with anyone whose immune system is not working properly, please inform the nurse/doctor. **If the person who is getting the vaccine has ever had a serious allergic reaction to the chickenpox vaccine, neomycin, or gelatin, please inform the nurse/doctor.**

Diphtheria, Tetanus, Pertussis (DTaP, Tdap, DT, Td) Diphtheria is a serious illness in which a thick membrane is formed in the back of the throat. This covering can cause breathing problems and even death. Tetanus (Lockjaw) causes muscles in the body to painfully tighten. Pertussis can cause severe coughing spells that can last for weeks. **DTaP is for children younger than 7 years; DT is for a child younger than 7 years who should not have the pertussis vaccine. Adolescents 11 through 18 years of age should receive 1 dose of Tdap; Td should be given for later booster doses.** Children who receive the DTaP, Tdap, or Td vaccine commonly experience soreness at the injection site, fever, fussiness, and poor appetite. Children who receive this vaccine rarely experience seizures, become less alert, or develop difficulty breathing.

Hepatitis A (HAV) is a serious liver disease caused by the Hepatitis A virus. Hepatitis A is spread by close personal contact and sometimes by eating food or drinking water containing Hepatitis A virus. Persons at risk should have this vaccine. Two doses, 6 months apart, are needed for lasting immunity. Soreness at the injection site, headache, loss of appetite and tiredness may occur 3 – 5 days after the shot has been given. Rarely does serious allergic reaction occur. **People who have had an allergic reaction to one dose should not receive the second dose.**

Hepatitis B (HBV) Hepatitis is a serious liver infection caused by the Hepatitis B virus. People with this infection are at risk for developing diseases such as liver cancer, cirrhosis, or even death. Three doses are required for total immunity. Potential side effects of this vaccine include soreness at the injection site and fever. **People who are allergic to baker's yeast should not receive this vaccine.**

Haemophilus Influenzae Type b (HIB) is a bacterium that can cause children to develop serious illness such as infection of his/her brain or heart. These infections can cause permanent problems such as brain damage or even death. **HIB vaccination is recommended for anyone under the age of 60 months (5 years).** Potential side effects of this vaccine include fever, swelling, or redness at the site of the injection. These reactions generally start within 24 hours of the vaccination and subside within 48 hours. **People who have had an allergic reaction to one dose should not receive another dose**

Human Papillomavirus (HPV) is spread through sexual contact. HPV is important mainly because it can cause cervical cancer in women. HPV vaccine is an inactivated (not live) vaccine which protects against 4 major types of HPV. HPV vaccine can prevent some genital warts and some cases of cervical cancer. **HPV vaccine is routinely recommended for girls and boys 11-12 years of age. The vaccine is also recommended for females 13-26 years of age and males 12 through 21 who did not receive it when they were younger.** Protection from HPV vaccine is expected to be long-lasting but vaccinated women still need cervical cancer screening because the vaccine does not protect against all HPV types that cause cervical cancer. HPV vaccine is given as a 3-dose series. **Anyone who has ever had a life-threatening allergic reaction to yeast, to any other component of HPV vaccine, or to a previous dose of HPV vaccine should not get the vaccine.**

Influenza is a serious disease caused by a virus that spreads from infected persons via the nose or throat of others. The "Influenza Season" in the U.S. is from November through April of each year. Influenza viruses change often. Therefore, influenza vaccine is updated each year to make sure it is as effective as possible. **Annual flu shots should be given to people at risk for getting a serious case of influenza or influenza complications and people in close contact with them. This includes people with long-term health problems (example: Asthma) or a compromised immune system.** The risk of the vaccine causing serious harm is extremely small. The virus in the vaccine is killed, so you **cannot** get influenza from the vaccine. Mild problems such as soreness at the injection site, fever, or aches may occur soon after shot and last 1 – 2 days. **Talk with a Doctor/Nurse before getting vaccine if you have had a serious allergic reaction to eggs or to a previous dose of influenza vaccine, or have a history of Guillain-Barre Syndrome (GBS). If your child has a fever or is severely ill, postpone the Influenza vaccine until the child has recovered.**

Measles, Mumps and Rubella (MMR) Measles and Rubella (German Measles) are diseases that can cause rashes, fever, seizures, brain damage, and death. Children with Mumps often experience fever, headache, and swollen glands. Less often these children may develop hearing loss and infections of their brain or spine. Risks associated with taking the MMR vaccine include soreness at the injection site, fever, and swollen glands in the cheeks or under the jaw, and joint pain/stiffness. Although rare, other problems that your child may develop include severe allergic reactions, bleeding, and seizures. **Persons should not be given this vaccine if they have experienced a severe allergic reaction to gelatin or to the drug neomycin, seizures, transfused with blood or blood products, or those who may be pregnant.**

Meningococcal Conjugate (MCV4) Meningitis is a serious illness caused by a bacterial infection which is the leading cause of bacterial meningitis in children 2 – 18 years of age. The vaccine can prevent 4 types of Meningococcal disease. **The vaccine is recommended for all children at the pre-adolescent visit (11- 12 years) or college freshmen. MCV4 is also recommended for individuals 11 – 55 years of age.**

Meningococcal Polysaccharide (MPSV4) prevents 4 types of Meningococcal disease, the same as the conjugate vaccine, and should be **used for children 2 – 10 years of age and adults over 55 who are at risk.**

Pneumococcal Conjugate (PVC) Pneumococcal infection causes serious illness and death. Pneumococcal infection causes serious disease in children less than 5 years of age and is the leading cause of bacterial meningitis in the United States. Risks associated with the PVC vaccine are redness, tenderness, or swelling at the site and/or mild fever. Severe reactions are rare. **Children should not get this vaccine if they had a severe allergic reaction to a previous dose.**

Pneumococcal Polysaccharide (PPV) is recommended in addition to PCV for certain high risk groups.

Inactivated Polio Vaccine (IPV) Polio is a disease that can cause severe muscle weakness, paralysis, and death. The risk of IPV causing serious harm is extremely small. A risk associated with the vaccine is soreness at the injection site. **Anyone who has ever had a serious allergic reaction to Neomycin, Streptomycin, or Polymyxin B should not receive IPV.**

Tuberculosis (PPD) Tuberculosis (TB) is a disease that is caused by mycobacterium tuberculosis that is spread through the air from one person to another. The bacteria is put in the air when a person with active TB disease coughs or sneezes. Tuberculosis can cause disability and/or death if not detected and treated appropriately. TB skin testing is recommended for children with risk factors. Periodic skin testing is also recommended if exposure is suspected.

WITH ANY VACCINE THERE IS A POSSIBILITY THAT A REACTION MAY OCCUR. Children, adolescents, or adults who are moderately or severely ill at the time the shot is scheduled should wait until they recover before getting the vaccine(s). IF ANY UNUSUAL PROBLEMS OCCUR SUCH AS TROUBLE BREATHING OR MAJOR CHANGES IN BEHAVIOR SEEK IMMEDIATE MEDICAL ATTENTION.