Student Name: _____
Date of Birth: _____

School Based Mental Health Services

Provided by
Bangor Health Center
309 S. Walnut, Bangor, MI 49013
Phone: 269-427-6800, ext. 3032 Fax: 269-427-6811

CONSENT

Child Name: _____
First Middle Initial Last
Child Date of Birth: _____ Male ❒ Female ❒ Gender _____

Child's Mailing Address: _____

Providing the following information is strictly voluntary and is not required for registration.
Race:
❒ **Caucasian** ❒ **Black** ❒ **American Indian** ❒ **Bi/multi-racial** ❒ **Asian** ❒ **Other:**
Ethnicity:
❒ **Hispanic** ❒ **Arab** ❒ **Non-Arabic/NonHispanic**

1st Parent/Guardian Name: _____Relationship:_____ DOB:_____

Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Best way to reach you during the day? Home/Cell/Work/Other (circle) May we leave a message? Yes/No (circle)

2nd Parent/Guardian Name: _____Relationship: _____ DOB:_____

Address: _____

Home Phone:_____ Cell Phone: _____ Work Phone: _____

Best way to reach you during the day? Home/Cell/Work/Other (circle) May we leave a message? Yes/No (circle)

Emergency Contact: _____Relationship to child: _____

Phone: _____

Primary Care Physician: _____ Phone: _____
Dentist: _____ Phone: _____

By signing this form, I certify I am the legal guardian of the above-named child and give my consent for my child to receive School Based Mental Health Services at South Walnut Elementary. I understand these services are provided through Bangor Health Center, a program of Van Buren Community Mental Health. Your participation is strongly encouraged. By signing this consent, you understand your child may be seen without you being present. **Consent for services may be withdrawn upon written notice to Bangor Health Center at any time.**

ASSIGNMENT of BENEFITS: I hereby assign all medical benefits be made directly to Van Buren Community Mental Health Authority on my behalf, for any services provided to the above named person. I authorize any holder of medical and other information about my child, to release to Medicaid and its agents, any insurance company, any other third party, state medical assistance agency, or any other governmental or private payor responsible for paying such benefits, any information needed to determine these benefits, or benefits for related services. I authorize a copy of this authorization to be used in place of the original. Release or exchange of information for other purposes will require a separate Release of Information form to be signed by parent or guardian. ***If you would like a copy of the Notice of Privacy Practices, please notify our office.***

SIGNATURE OF PARENT/GUARDIAN:_____ DATE: _____

Student Name: _____
Date of Birth: _____

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INSURANCE INFORMATION

All counseling visits are recorded in the electronic medical record and a claim will be generated to the health insurance. We accept insurance payment as payment in full. We do not bill patients for their portion of the claim. Patients without insurance are served without a charge.

Primary Insurance:

Health Insurance Plan: _____
Contract #/Member ID #: _____ Group #: _____
Employer: _____ Address (if known): _____
Policy Holder Name: _____ Relationship to patient: _____
First Last
Policy Holder's Date of Birth: _____ Social Security #: _____

Secondary Insurance:

Health Insurance Plan: _____
Contract #/Member ID #: _____ Group #: _____
Employer: _____ Address (if known): _____
Policy Holder Name: _____ Relationship to patient: _____
First Last
Policy Holder's Date of Birth: _____ Social Security #: _____

*** **Please alert Bangor Health Center of any change in insurance information** ***

Bangor Health Center provides services to all eligible youth regardless of sex, race, creed, color, religion, national origin, sexual orientation, gender identity or expressions, or disability.

Services are provided regardless of ability to pay or insurance status.

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Date of Birth: _____

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HEALTH HISTORY

Please fill out this Health History Questionnaire for your child. **Today's Date**: _____

Child's name: _____ Date of Birth:_____Current Grade:_____
Patient's Primary Care provider: _____
Approximate date of last physical: _____
Patient's specialist (ex. cardiologist, endocrinologist, psychiatrist etc. - leave blank if patient does not see specialist): _____
_____
Preferred Pharmacy: _____

Who lives in the home?

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Medications: ☐ My child does not take any medications

Name of medicine:	Dose:	Reason for taking:	Prescribed by:
_____			
_____			
_____			
_____			

Allergies: ☐ My child does not have any allergies to any medications

Name of medicine:	What type of reaction:
_____	
_____	
_____	

Patient's Health Conditions: Please check yes or no related to your child's health

	Yes	**No**	**Unsure**
Asthma			
Depression / Anxiety			
Learning Disability			
Diabetes			
Heart Problems/Murmur			
Seizures / Epilepsy			
Other (specify)			

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Has your child ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type or surgery? ☐ No: ☐ Yes: If yes, what age? _____

Problem/Type of Surgery?_____

Family History:
Some health problems are passed from one generation to the next. Have you or your child's blood relatives (parents, grandparents, brothers, or sisters), living or deceased, had any of the following problems?

☐ Unknown family history ☐ Adopted

	Yes	**No**	**Unsure**	**Relationship**
Allergies/Asthma				
Cancer (type)				
Depression				
Diabetes				
Heart Attack or stroke *Before* age 50				
High blood pressure				
High cholesterol				
Mental illness				
Migraine headaches				
Substance Abuse				
Tobacco Use				
Others (specify)				

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Your Rights

- **You and your child have the right to be treated with respect and dignity.**
- **You and your child have the right to receive care in our program: regardless of race, religion, national origin, gender, sexual orientation, ability to pay or handicap.**
- **You and your child have the right to privacy.**
- **You and your child have the right to discuss with your mental health care provider any questions or problems you may have.**
- **You and your child have the right to refuse any treatment you do not want or do not understand, unless you are a danger to yourself or others.**
- **You and your child have the right to understand why certain information is requested or why certain care is suggested.**

Your Responsibilities
What you need to do….

- **You are responsible for treating health care providers with respect.**
- **You are responsible for answering questions and telling the truth about your child's health.**
- **You are responsible for showing respect and privacy for others using the program.**
- **You are responsible for asking questions about anything you do not understand.**
- **You are responsible for telling the South Walnut Mental Health Clinician Bangor Health about any significant changes in your health.**