

# HENRY FORD HEALTH

Department of Pediatrics

School-Based and Community Health Program (SBCHP) Health Center

**Consent Form:** To be completed by Parent/Guardian or Patient (age 18 or over)

Patient's legal name (first, last, middle initial) \_\_\_\_\_

**I understand and agree to the following:**

- **This consent form is valid until the child turns 18. At that time they can sign their own consent form.**
- **I can cancel this consent by giving a written letter to the health center.**
- The patient may get medical and behavioral health care at the Henry Ford Health School Based and Community Health Center (health center).
- The patient may get telehealth or virtual health care from a Henry Ford Health doctor or provider.
- The health center can share the patient's health information with other health care and behavioral health providers.
- The health center may give information about treatment to insurance companies or others to get payment for services.
- If the patient needs prescription medicine and it is delivered to the school, the patient may bring the medicine from school to home with no supervision.
- Health Center staff will call 9-1-1 first, and then they will call the parent or guardian if there is an emergency.
- I do not need to give permission or consent for emergency transportation
- I received a copy of the Henry Ford Health Notice of Privacy Practices.

Check one of the below:

- ☐ I am the parent or legal guardian of the child who is under the age of 18.
- ☐ I am the patient named above and 18 years of age or older.

Signature

Date

**I agree that:**

- The health center can get a copy of the patient's vaccine record from the school office, primary care provider's office, local health department, or MCIR (Michigan Care Improvement Registry).
- I understand that a form explaining any vaccines the child needs and specific vaccine information sheets (VIS) will be shared with me.
- **The health center will not give the patient any vaccines until written or verbal consent has been given by the parent/guardian at the time of service.**

Check one of the below:

- ☐ I am the parent or legal guardian of the child who is under the age of 18.
- ☐ I am the patient named above and 18 years of age or older.

Signature

Date