ACCESS Child and Adolescent Health Center
Parent/Guardian/ Patient
**Registration/ Consent Form**

| Patient Name | Birth Date | Age | M/F | Social Security Number | School Name |
|---|---|---|---|---|---|
| | | | | | |

Race/ Ethnicity (optional)
☐ African American ☐White ☐Hispanic ☐Arab American ☐Asian ☐ Other

| Address | City | Zip Code | Home Phone Number |
|---|---|---|---|
| | | | |

| Parent/ Guardian: Last Name | First Name | Mi.I | Relationship to Patient |
|---|---|---|---|
| Daytime Phone Number | Work Phone Number | | Cell Phone Number |
| Emergency Contact | Relationship to Patient | | Telephone Number |
| Name of Patient's Doctor/ Clinic | | | Telephone Number |
| Name of Patient's Dentist | | | Telephone Number |

Insurance:
☐ Medicaid ☐Blue Cross Blue Shield ☐ HAP ☐Other: ____________________ ID# ____________________
☐ I do not have insurance ☐ Yes, I would like more information on obtaining insurance Date Enrolled __________

Sliding Scale Fee: (select the appropriate box based on your income)

| Household Income | Poverty level | % of total fee per service |
|---|---|---|
| $0 - $11,000 | 100% | minimum fee |
| $11,000- $21,000 | 125% | 50% |
| $21,000-$41,000 | 150% | 70% |
| $41,000- $71,000 | 175% | 80% |
| $70,000- $100, 000 | 200% | 100% |

Number of members within your household: ______________________

## Consent

I consent to all of the following:

- **The ACCESS Child &Adolescent Health Center may share health care information with other providers for the purposes of continuity and coordination of care.**
- **The ACCESS Child &Adolescent Health Center may release information regarding treatment to third party payers or others for the purpose of receiving payment for services.**
- **The Child & Adolescent Health Center may obtain a copy of the above named patient's immunization record form the patient's school office, primary care provider, and/ or local health department.**

*By signing this consent form, I certify that I am the guardian of the above named patient under the age of 18. I understand that I may withdraw my consent for services upon written notice to the Center at any time. I acknowledge receiving a copy of the ACCESS Child and Adolescent Health Center Notice of Privacy Practice, HIPAA Notice, and Patient Rights and Responsibilities.

Signature of Parent/ Guardian/ Patient: ______________________________ Date: ________________

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## Patient Medical History:

| Please check yes or no for each item | Yes | No | | Yes | No |
|---|---|---|---|---|---|
| Bee sting allergies | | | Anemia (low iron/ blood count) | | |
| Medication allergies (type:____________________) | | | Stomach problems | | |
| Food allergies (type:_________________________) | | | Heart problems | | |
| Allergies (dust, pollen, pets, etc.) | | | Bladder problems (i.e. bedwetting) | | |
| Asthma | | | Taking daily medication(s) | | |
| Diabetes (blood sugar problems) | | | Name of medication(s), dosage & directions ______________________________________________ | | |
| Eczema/ Rashes | | | | | |
| Headaches/ Migraines | | | Condition for medication(s) (i.e. asthma, allergies, ADHA, etc.) __________________________________ | | |
| ADD/ ADHA (attention deficit disorder) | | | | | |
| Hypertension (high blood pressure) | | | Fainting | | |
| Sickle cell trait | | | Shortness of breath | | |
| Sickle cell disease | | | Nosebleeds | | |
| Pneumonia | | | Frequent sore throats | | |
| Kidney disease | | | Surgeries | | |
| Painful joints | | | Surgeries (i.e., tonsils, ear tubes, hernia, appendix) Type: | | |
| Backaches | | | | | |
| Seizure (epilepsy) | | | Overnight Hospitalizations Reason: | | |
| Other health problems: | | | | | |

## Family Medical History:

Please check below if any of your child's relatives (i.e. mother, father, sister, brother, aunt, uncle, grandparents) have had any of the following illnesses and note what relative had them.)

| | | | |
|---|---|---|---|
| | Heart Problems ______________________________ | | Cancer ___________________________________ |
| | Cholesterol __________________________________ | | Diabetes (high blood sugar) _______________________ |
| | High Blood Pressure ____________________________ | | Stroke _____________________________________ |
| | Asthma/ Emphysema/ Bronchitis ___________________ | | Seizures ____________________________________ |
| | Death under age 50 (cause:______________________ ) | | Kidney _____________________________________ |
| | Sickle cell anemia/ blood problems _________________ | | Other (describe): ___________________________ |

Services provided at the Child and Adolescent Health Center

*Parental consent is required for the following services provided to patients under the age of 18:*

- Physical exams for school, sports, and camp.
- Treatment for acute, chronic illness, &injuries
- Vision/ hearing screenings and follow-ups.
- Oral/ dental screening and follow-up.
- Immunizations
- Basic laboratory services & tests
- Administration of medication
- Individual, group, family, and community education.
- Referrals for specialty services

*Current Michigan Law allows for confidential services to mature minors in these areas:*

- Gynecological services
- Pregnancy testing & referrals
- Sexually transmitted disease education, screenings, treatment, and counseling
- HIV education, screening, and referrals
- Crisis Intervention
- Substance abuse education, counseling &referrals
- Mental health education, assessment, counseling, and referrals

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