Dear Parents/Guardians:

Re: School Wellness Program (SWP) Consent Form and Consent for Immunizations

The attached forms will give permission for your student to receive services from the school nurse and/or clinical therapist. These services could include over the counter medications (Ex. Tylenol or Motrin) and immunizations, if your student is not up to date. Without a signed consent form (one form per student) your student will not be able to receive some of the services offered. This consent form is good until your student graduates from Flint Community Schools. If your student leaves the district and comes back then a new consent form is needed. The consent form should be up-dated if your child has any health changes that we should be aware of. Our goal is to keep your child in class and learning!

The first consent form in the packet is the SWP Consent Form. It is two pages and needs a signature on the second page. Please complete the whole form and answer ALL questions. The second consent for is for immunizations. It is one page and needs a signature at the top. Again, please complete the whole form.

When both forms are completed and signed, please return to your school office or school nurse.

**THIS FORM DOES NOT PERTAIN TO DAILY PRESCRIPTION MEDICATIONS THAT YOUR CHILD MAY HAVE TO TAKE AT SCHOOL. FOR PRESCRIPTION MEDICATIONS A MEDICATION CONSENT FORM AND/OR EMERGENCY ACTION PLAN MUST BE COMPLETED. THESE FORMS MAY BE ATTAINED IN THE SCHOOL OFFICE FROM THE SECRETARY.**

Please contact Flint Community Schools Health Services with any questions or concerns 810 424-4087.

Thank you,

Eileen Tomasi, BSN, RN
### Flint Community Schools Wellness Center

**Parent/Guardian Consent Form**

<table>
<thead>
<tr>
<th>Name (Last Name, First Name, M.I.)</th>
<th>Birth Date</th>
<th>Age</th>
<th>Sex</th>
<th>Grade</th>
<th>School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>Zip Code</td>
<td>Student Telephone</td>
<td>Today's Date</td>
<td></td>
</tr>
</tbody>
</table>

**Race/Ethnicity (optional)**

- [ ] Black/African American
- [ ] White
- [ ] Hispanic/Latin
- [ ] American Indian/Alaskan Native
- [ ] Asian
- [ ] Native Hawaiian/Pacific Islander

<table>
<thead>
<tr>
<th>Parent/Guardian Last Name</th>
<th>First Name</th>
<th>M.I.</th>
<th>Relationship to Student</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daytime Telephone #</td>
<td>Work Telephone #</td>
<td>Cellular #</td>
<td>Parent Email Address</td>
</tr>
<tr>
<td>Name of Emergency Contact</td>
<td>Relationship</td>
<td>Telephone #</td>
<td></td>
</tr>
<tr>
<td>Name of Student's Physician/Clinic</td>
<td>Telephone #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Student's Dentist</td>
<td>Telephone #</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Insurance</td>
<td>Preferred Hospital</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I.D. Contract #</td>
<td>Policy/Group #</td>
<td>Student Relationship to Policy Holder</td>
<td></td>
</tr>
<tr>
<td>Policy Holder Name (Last Name, First Name, M.I.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>Zip Code</td>
</tr>
</tbody>
</table>

- I consent to all of the following:
  - The above named may receive services at the Wellness Center by the Registered Nurse and/or *Licensed Mental Health Provider.*
  - This consent remains active until rescinded or the student reaches age 18.
  - I understand that any changes to my information, or to rescind this consent, must be submitted in writing.
  - I understand that the Wellness Center and my child’s primary provider may exchange health information for continuity of care.
  - I authorize the Wellness Center to disclose protected health information from a visit for continuation of treatment, operations and internal peer review audit.
  - I authorize the Wellness Center to obtain my student’s academic, discipline, and absence data for program evaluation purposes.
  - I understand that a confidential risk assessment survey will be given to all students and/or parents.
  - I understand that State law allows certain confidential services for students that meet age criteria (see page 2)
  - I understand that currently there is no cost for limited-clinical or mental health services, and I will not be billed.
  - I understand that I am under no obligation to have my child use the Wellness Center services.
  - I understand that

  **By signing the back of this consent form, I certify that I am the parent/legal guardian of the student named above and am registered with the school as such.**

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By signing the back of this consent form, I certify that I am the parent/legal guardian of the student named above and am registered with the school as such.
Student Medical History: Please check yes or no

Bee sting allergies       yes no   Seizures (epilepsy)       yes no   Psychological disorder       yes no
Anemia                   yes no   Stomach problems         yes no   Thyroid disease             yes no
Seasonal allergies       yes no   Heart problems           yes no   Frequent sore throats       yes no
Asthma                   yes no   Bladder problems         yes no   Nosebleeds                  yes no
Diabetes                 yes no   Cancer                   yes no   Backaches                  yes no
Eczema/rashes            yes no   Headaches/migraines     yes no   Frequent urination         yes no
ADD/ADHD                 yes no   High blood pressure     yes no   Kidney disease             yes no
Sickle cell disease/trait yes no   Fainting               yes no   Shortness of breath       yes no
Pounding of heart        yes no   Pneumonia               yes no   Learning Disability       yes no

Does anyone smoke in the household? yes no

Student’s Daily Medications? ____________________________________________________________
Condition for Medications? ____________________________________________________________
Any Medication Allergies? _____________________________________________________________
Any Food Allergies? _________________________________________________________________
Any Surgeries? _________________________________________________________________________
Any Hospitalizations? ________________________________________________________________
Other health problems? ______________________________________________________________

Family Medical History
Check any illnesses that relatives (i.e. mother, father, aunt, uncle, grandparents, sibling) and note which relative has them

[ ] Heart Problems [ ] Cancer
[ ] Cholesterol [ ] Diabetes (high blood sugar)
[ ] High Blood Pressure [ ] Stroke
[ ] Asthma/Emphysema/Bronchitis [ ] Seizures
[ ] Death under age 50 – Cause: [ ] Kidney or Thyroid Disease
[ ] Sickle Cell Anemia/Blood problems [ ] Other

Parental consent is required for the following services provided the student/patient is under the age of 18:
- Treatment for acute & chronic illness & injuries
- Immunizations
- Basic laboratory services & tests
- Individual, group, family counseling
- Referrals for specialty services
- Possible administration of the following medication: Acetaminophen, Ibuprofen, Antihistamine, Benadryl, Triple anti-biotic ointment, Hydrocortisone crème, cough drops, antacid, eye drops and 1% Permethrin for head lice.

Current Michigan Law allows for confidential services to minors in these areas:
- For Students 12 years or older:
  - Pregnancy testing and referrals
  - Sexually transmitted disease screenings, treatment and counseling
  - HIV screening and referrals
- For students 14 years or older
  - Any Mental health assessment, counseling and/or referrals

Please note: Students can access these services confidentially, at these ages, at ANY clinic, not just a school-based Wellness Center.

*These services provided only at the following Schools: Flint Junior High School, Freeman, Holmes STEM, and Potter.

Parental consent is NOT needed for crisis intervention and emergency care

LIMITATION OF SERVICES: NO birth control pills, or devices will be dispensed or prescribed; NO abortion counseling, referrals or services are provided.

Signature of Parent/Guardian ___________________________________________ Date: __________

Free or low-cost health coverage for children under the age of 19,
or pregnant women of any age
Call the MI Child and Healthy Kids hotline at 1.888.988.6300 or apply online at www.michigan.gov/mibridges
Health care coverage & services for eligible people up to age 21 years
and pregnant women exposed to the Flint water since April 2014
Call 1.855.789.5610 or apply online at www.michigan.gov/mibridges
I give my permission for my child to receive any of the vaccines listed below by the Flint Community Schools’ Nurse, if needed. This consent form along with the School Wellness Consent form is valid as long as my child attends a Flint Community School. The nurse will send home a copy of the Vaccine Information Statement(s) (VIS) for any vaccines my child is given. Some of the vaccines may be combined. I understand my child’s immunization records from the Michigan Childhood Immunization Registry (MCIR) will be reviewed. I consent to inclusion of this immunization data in MCIR on behalf of my child.

DTaP    Tdap    HepA    HepB    HPV    Influenza    Meningococcal    MMR    Polio/IPV    Varicella    Other

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**Signature of Parent/Guardian**

**Date**

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**CHILD INFORMATION**

Child’s Last Name: (Printed)  Child’s First Name:  Phone Number:  Age:  Birth date:  

Parent/Guardian’s Last Name (Printed):  Parent/Guardian’s First Name (Printed):  

**Ethnicity:** Hispanic or Latino  **Race:** (Select one or more.)  

____ Yes  ____ No

__ African American/Black
__ American Indian/Alaska Native
__ Arab/Chaldean
__ Asian

**Gender:**  

____ Male  ____ Female

**Primary Care Physician:**

Phone:  Fax:  

**CHILD ELIGIBILITY**

Medicaid  Private Insurance (Name)  No health insurance  Under Insured  Native Am/Alaska Native  

Subscriber Name: (Private Insurance-Only)  Insurance Contract Number:  Group Number:  

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**IMMUNIZATION SCREENING QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>CIRCLE</th>
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<tbody>
<tr>
<td>1. Is your child sick today?  yes  no</td>
</tr>
<tr>
<td>2. Does your child have allergies to medications, food, a vaccine component, or latex?  yes  no</td>
</tr>
<tr>
<td>3. Has your child had a serious reaction to a vaccine in the past?  yes  no</td>
</tr>
<tr>
<td>4. Has your child had a health problem with lung, heart, kidney, or metabolic disease (e.g., diabetes), asthma, or a blood disorder? Is he/she on long-term aspirin therapy?  yes  no</td>
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<tr>
<td>5. Has your child, a sibling, or a parent had a seizure; has your child had brain or other nervous system problems?  yes  no</td>
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<tr>
<td>6. Does your child or family member have cancer, leukemia, HIV/AIDS, or any other immune system problem?  yes  no</td>
</tr>
<tr>
<td>7. In the past 3 months, has your child taken medications that affect their immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn’s disease, or psoriasis, or had radiation treatments?  yes  no</td>
</tr>
<tr>
<td>8. In the past year, has your child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?  yes  no</td>
</tr>
<tr>
<td>9. Is your child/teen pregnant or is there a chance she could become pregnant during the next month?  yes  no</td>
</tr>
<tr>
<td>10. Has your child received vaccinations in the past 4 weeks?  yes  no</td>
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</tbody>
</table>
(Circle the appropriate vaccine, site, route, and enter the VIS date, manufacturer lot # and expiration date)

FOR NURSES USE ONLY

<table>
<thead>
<tr>
<th>VACCINE</th>
<th>DELTOID SITE</th>
<th>ROUTE</th>
<th>VIS DATE</th>
<th>MANUFACTURER LOT #</th>
<th>EXP DATE</th>
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<tbody>
<tr>
<td>DTaP</td>
<td>RT LT</td>
<td>IM</td>
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<td>Polio</td>
<td>RT LT</td>
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<td>Hep B</td>
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<td>MMR</td>
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<td>DTaP/IPV</td>
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<td>Kinrix</td>
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<td>Hep A</td>
<td>RT LT</td>
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<td>HPV 9</td>
<td>RT LT</td>
<td>IM</td>
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<td>Meningococcal MCV4</td>
<td>RT LT</td>
<td>IM</td>
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<td>Tdap</td>
<td>RT LT</td>
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<td>Men B Bex</td>
<td>RT LT</td>
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<td>VAR/MMR ProQuad</td>
<td>RT LT</td>
<td>SC</td>
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<tr>
<td>Influenza</td>
<td>RT LT</td>
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Signature of Nurse

Date