School Based Behavioral Health Clinic

Brimley Area Public Schools

Chippewa County Health Department

7134 S. M-221
Brimley, MI 49715
906 632 5690 (phone)
906 635 1325 (fax)

PARENT/GUARDIAN CONSENT FORM

Please read and complete. Consent contains 2 pages

Consent is needed for each student if: one has not previously been completed OR any changes have occurred since the last form was completed.

Student Name (Last Name, First Name, Middle Initial) *	**Birth Date ***	**Age**	**Sex *** Male ❒ Female ❒	**Grade**	**School**
Address *	**City ***	**Zip Code ***	**Student Telephone #**		**Today's Date**

Race / Ethnicity (Optional)

❒ **Black or African American** ❒ **White** ❒ **Hispanic/Latino** ❒ **American Indian/Alaskan Native** ❒ **Arab** ❒ **Asian** ❒ **Native Hawaiian/Pacific Islander**

Mother/Guardian: Last Name	**First Name**	**M.I.**	**Relationship to Student**
Daytime Telephone #	**Work Telephone #**	**Cellular / Pager #**	**Parent E-Mail Address**
Father/Guardian: Last Name	**First Name**	**M.I.**	**Relationship to Student**
Daytime Telephone #	**Work Telephone #**	**Cellular / Pager #**	**Parent E-Mail Address**
Name of Emergency Contact	**Relationship**	**Telephone #**	
Name of Student's Physician/Clinic	**Telephone #**		
Name of Student's Employer	**Your estimate of student's annual income**		

Medical Insurance *

❒**Medicaid** ❒ **Blue Cross/Blue Shield** ❒ **NGS Insurance** ❒ **MI Child** ❒ **TRICARE** ❒ **Other: _____** ❒ **No insurance**

I.D./Contract # *	**Policy/Group # ***	**Student Relationship to Policy Holder ***
Policy Holder Name (Last Name, First Name, Middle Initial) *	**Policy Holder Date of Birth ***	**Please provide a photocopy of both sides of your insurance card.**
Address *	**City ***	**State *** / **Zip Code ***

Secondary Insurance *

❒**Medicaid** ❒ **Blue Cross/Blue Shield** ❒ **NGS Insurance** ❒ **MI Child** ❒ **TRICARE** ❒ **Other: _____** ❒ **No insurance**

I.D./Contract # *	**Policy/Group # ***	**Student Relationship to Policy Holder ***
Policy Holder Name (Last Name, First Name, Middle Initial) *	**Policy Holder Date of Birth ***	**Please provide a photocopy of both sides of your insurance card.**
Address *	**City ***	**State *** / **Zip Code ***

(Turn over and complete)

I consent to all of the following:

- The above-named student may receive services at the School Based Behavioral Health Clinic. If I am requesting any changes to this consent, I will submit the changes in writing separately.
- The completion of a risk assessment by the above-named student.
- The School Based Behavioral Health Clinic may release information regarding treatment to third party payers or others for the purpose of receiving payment for services. If required by law, separate release forms will be used at time of service.
- Both the School Based Behavioral Health Clinic and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- This consent form will remain active and on file at the School Based Behavioral Health Clinic while my student is enrolled in school in Chippewa County, unless rescinded by me in writing.

Services provided at the Brimley Area School/CCHD - Behavioral Health Clinic

Current Michigan Law allows for confidential services to mature minors in these areas:
➢ Physical/sexual abuse counseling and referrals ➢ Crisis Intervention ➢ Substance abuse education, counseling and referrals ➢ Mental health assessment, counseling, and referrals

PARENTAL CONSENT IS NOT NEEDED FOR CRISIS INTERVENTION AND EMERGENCY CARE

By signing this consent form, I certify that I am the parent/legal guardian of the student, or student at least 18yrs old, named above and is registered with the school as such.

SIGNATURE OF PARENT/GUARDIAN:_____ DATE: _____
(or student at least 18yrs old)

We serve students enrolled in Brimley Area Schools, without regard to race, religion, color, national origin, creed, handicap, sex, sexual orientation, or sexual preference. Services are also provided to infants and pre-school children of students.

Consent and Statement of Understanding Regarding Telehealth (Online Therapy) Sessions

I hereby authorize Sault Health Adolescent Care Center to use HIPAA compliant telehealth technology for my therapy sessions. I understand that to maintain my confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment.

I understand that telehealth is not an appropriate option for emergency services. If I experience suicidal/homicidal thoughts, I am aware and agree that I will be referred for in-person crisis services to my local emergency room or community mental health emergency services. I authorize my therapist to contact my parent or emergency contact if they believe I may be in any danger during the therapy session.

I understand that my provider or I can discontinue the telehealth consult/visit if it is felt that the telehealth service is not adequate for the situation.

By signing below, I acknowledge that I have read, understand, and have been able to ask any questions about this service, and that these questions have been answered to my satisfaction.

☐ Yes, I agree to Telehealth services ☐ No. I do not agree

Student Signature _____Date:_____

Parent/Guardian Signature _____Date:_____