School ____________
Grade ____________
Teacher ____________

Registration & Health History Form

Child's Last Name	First Name	Middle Initial	Date of Birth	Sex
Street Address	Apt. #	City	State	Zip Code

Parent/Guardian	DOB	Home Telephone Number ( )	Daytime Number ( )	Cell Number ( )
Parent/Guardian	DOB	Home Telephone Number ( )	Daytime Number ( )	Cell Number ( )

Race	❑ White ❑ Asian	❑ Black / African American ❑ American Indian / Alaska Native	❑ Native Hawaiian ❑ Other Pacific Islander	❑ Choose not to disclose ❑ Other____
Ethnicity	❑ Hispanic or Latino ❑ Arab/Chaldean	❑ Not Hispanic or Latino ❑ Unreported/Choose not to disclose	Language	❑ English ❑ Spanish ❑ Burmese ❑ Other____

Reporting yearly household size and income is a government requirement that will allow Grace Health to continue to receive funding to provide special services for our patients. Please support these programs by providing the following information:

Number of people living in home: ________ *Total household income:* ____________ *Choose not to disclose:* ____

INSURANCE INFORMATION: Please complete ALL relevant areas below.

Insurance: ❐ Yes ❐ No Please contact me about MI Child/Healthy Kids Health Insurance for my child: ❐ Yes ❐ No

Primary Insurance:	Subscriber Name:	Subscriber/Policy Number:
	Subscriber Birth Date:	
Secondary Insurance:	Subscriber Name:	Subscriber/Policy Number:
	Subscriber Birth Date:	
Name of Primary Care Physician:		Date of Last Physical:

Allergies to Medications:

DAILY MEDICATIONS: Please list any medications the student takes regularly.

	Name of Medicine		***Name of Medicine***
1		2	
3		4	

STUDENT HEALTH HISTORY: Please X the YES column if any of these conditions apply to the student or mark here for ❐ NONE.

Condition	***YES***	***Condition***	***YES***	***Other Conditions:***
ADHD/ADD		Diabetes		
Allergies:		Emotional Behavior		
• Bee Sting		Experienced Trauma Event		**Surgeries/Hospitalizations:**
• Food		Headaches/Migraines		
• Seasonal		Seizures		
Emergency treatment needed? ☐ Y ☐ N		Emergency treatment needed? ☐ Y ☐ N		
Asthma		Secondhand Smoke		
Emergency treatment needed? ☐ Y ☐ N		Other:		
Cancer				

FAMILY HEALTH HISTORY (parents/siblings): Please X the YES column if any of these conditions apply to the family or mark here for ❐ NONE.

Condition	***YES***	***Condition***	***YES***	***Other Conditions:***
Allergies:		Emotional Behavior		
		Heart attack or death before age 50		
Asthma		Hypertension/High Blood Pressure		
Cancer		Overweight/Obesity		
Cholesterol Elevated		Seizure		
Diabetes: Type I or II		Smoking		

Health Services Consent Form

Student Health Centers

Student Name:_________________________________ **Birthdate:**____/____/____

Consent for Services

Services may include: mental health services (individual, family and group counseling); and medical services, including: treatment for acute illness and injuries; physical exams, i.e. well child, sports and camp; basic laboratory services and tests; referral for specialty health services; student health assessment, education, and risk counseling and testing; Medicaid outreach and enrollment; administration of over the counter medications , i.e., ibuprofen, acetaminophen, loratadine in accordance with established protocols developed by Grace Health and allow consultation with a Grace Health provider via Telehealth on an as-needed basis. Not all services are available with all programs.

- For Parents/Guardians – I give consent for my student to receive the services described above until age 18. I understand it is not necessary to renew my consent yearly. I authorize Grace Health to bill my insurance company and release related information necessary to complete the billing process for services provided. I further authorize the exchange of health care information regarding treatment to other medical or mental health providers for the purpose of continuity and coordination of care. I agree to allow conversation with school staff when academic success is related to a health issue. I understand I may withdraw my consent for services at any time upon written notice. I understand that I may be billed for services not covered by insurance.
- I understand that testing for blood borne diseases, including HIV/AIDS, may be performed upon a patient without separate written consent in the event that a healthcare professional receives a cut or exposure to blood or body fluids.
- I understand that as an entity of Grace Health, these programs participate in and recognize the rules of the Health Information Portability and Accountability Act (HIPAA). In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information/records. In a medically appropriate situation, pertinent information will be given to the parent/guardian and/or others as permitted or required by law. The individual is also provided the right to request confidential communications or communications by alternative means such as to a cell phone instead of the home phone.
- I have been given or have had the opportunity to review the Grace Health Notice of Privacy Practices (located at https://www.gracehealthmi.org/privacy-practices/) and may also be provided a copy upon request.
- I have reviewed, understand and consent to the services offered.
- By signing this form I certify that I am the legal guardian and/or legal custodian of the student listed above.

_________________________________ ________________

Signature of Parent/Guardian/Client 18 years and older **Date**

Consent for Immunizations

I understand immunization (shot) records from the Michigan Care Improvement Registry (MCIR) will be reviewed. I give my permission for any required or recommended shot(s) to be given if needed and that the administration be recorded in MCIR. View vaccine information sheets at: http://www.michigan.gov/mdhhs/0,5885,7-339-73971_4911_4914-138197--,00.html#Vaccine_Information_Statements_(VIS)

_________________________________ ________________

Signature of Parent/Guardian/Client 18 years and older **Date**

Michigan law mandates (requires) confidential services to minors without the consent or knowledge of a parent/guardian. Confidential services include advice, testing and/or treatment for drug abuse, substance abuse, sexually transmitted diseases, pregnancy testing, and referral for birth control services. These confidential services are available for minors 12 years of age or older. Additionally, a minor 14 years of age or older can, without parental consent, obtain limited outpatient mental health services not to exceed 12 visits over four months and not to include any medications. People who are age 18 or older, legally emancipated, legally married, under court-order, in the presence of a law officer when the parent cannot be promptly located, and/or members of the US Armed Forces provide consent for services themselves. Services are rendered without regard to sex, race, religion, sexual orientation or gender identity.

No birth control pills or devices are dispensed or prescribed by these programs. The student will be given a referral list of community agencies that provide these services. No abortion counseling, referrals, or services are provided.

CRISIS INTERVENTION AND EMERGENCY CARE DO NOT REQUIRE PARENTAL CONSENT

Medication Administration Authorization

School District: ____________________ School: ____________________ Fax: ________________

AUTHORIZATION FOR THE ADMINISTRATION OF MEDICINE BY SCHOOL PERSONNEL

Michigan State Law (PA 51 of 2002) requires a written medication order by a medical provider and parent/guardian written authorization for designated individuals to administer medication to pupils at school. Medications must be in the original properly labeled container and dispensed by a medical provider/pharmacist.

- Medication must be delivered to school office by a parent. (students are not allowed to bring in medication)
- A separate authorization form must be completed for each medication.
- Parent assumes responsibility to inform the office of any change in medication.

Medical Provider/Prescriber Authorization

Name of Student: ____________________ **Date of Birth:** __________ **Grade:** __________

Address: ____

Condition for which drug is being administered: ________________________________

Name and Generic Name of Drug: ____________________ **Frequency:** __________

Dose: ______________ **Time of Administration:** ☐ **Lunchtime** ☐ **Other – Specify:** __________

Relevant side effects: ☐ None expected ☐ Specify: ________________________

Allergies: ☐ No ☐ Yes – Specify: ________________________

Medication shall be administered from: ____________________ **to** ____________________
(Month / Day / Year) (Month / Day / Year)

Students may self-administer medication such as inhalers for asthma, cartridge injectors for medically diagnosed allergies, and insulin for diabetes. Some school policies (high school) also allow students to carry non-prescription medication such as non-narcotic analgesics for pain or cramps or antacid tablets such as Tums and prescription medications such as antibiotics for self-administration with the written authorization of an authorized prescriber and written authorization from a student's parent or guardian or eligible student.

Medical Provider/Prescriber's authorization for self-administration: ☐ **Yes** ☐ **No**

Medical Provider/Prescriber's Name/Title: ________________________________

Telephone: ____________________ Fax: ____________________

Address: ____

Medical Provider/Prescriber's Signature: ____________________ **Date:** __________

Parent/Guardian Authorization

I hereby request that the above ordered medication be administered by school personnel and I give permission for the exchange of information between the prescriber and the school nurse necessary to ensure the safe administration of this medication. I understand that I must supply the school with no more than a three (3) month supply of medication. **I understand that this medication will be destroyed if not picked up within one week following termination of the order or the last day of school, whichever comes first.**

Parent/Guardian authorization for self-administration: ☐ **Yes** ☐ **No**

Parent/Guardian Signature: ________________________________ **Date:** __________

Parent's Phone Number: Home: __________ Cell: ______________ Work: ______________

School Nurse approval for self-administration: ☐ **Yes** ☐ **No**

School Nurse Signature: ________________________________ **Date:** __________

Grace Health
181 West Emmett Street
Battle Creek, MI 49037-2963
(269) 965-8866

Effective: April 14, 2003
Revised: July 1, 2019

Grace Health
115 Market Place
Albion, MI 49224-1767
(517) 629-6540

Notice of Privacy Practices

This Notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We create a record of all the medical, pharmacy and dental services that you receive at Grace Health. This record contains information about your symptoms, examinations, test results, x-rays, diagnoses, treatment, our plan for future care and the services we have provided.

At Grace Health, we respect our patients and their personal information. We are committed to protecting the privacy of patient records. We are also required by state and federal laws to maintain the privacy of protected health information.

One of the requirements of the federal Privacy Rules is to provide patients with a Notice of Privacy Practices. This notice tells how we may use your patient information and how it may be disclosed to others. It also explains your rights and some of our legal obligations regarding your health records.

Uses and disclosures of health information

Grace Health employees may use or disclose your patient information to provide treatment, obtain payment and carry out health care operations.

Treatment: Your patient information is used by the people taking care of you at our office. We may also share information with others who are helping us provide treatment for you, such as a medical specialist, hospital, laboratory or pharmacy.

Payment: Your patient information may be used as we bill and collect payment for the treatment and services you receive. We may contact your insurance company to verify coverage, and we may share the information with them to obtain payment for services we have provided or to request authorization for treatment. Information may be disclosed to our collection agency in case of non-payment for services.

Operations: We may use your health information as we operate and manage our practice and to make sure that you and our other patients receive quality care. This includes using patient information to evaluate the performance of our staff, to find ways to become more efficient and to decide what services to offer. When information is shared with others who provide business services for our organization, they are also required to protect the privacy of our patient information.

Appointment reminders and leaving messages: We may contact you or leave a message on an answering machine or with a household member to remind you of your appointment. We may also leave messages about the status of services we are providing for you or to request return calls to our office.

Text messaging: If you share your cell phone number with us, appointment reminders and payment alerts may be sent in text messages. We may also send you information about tests, appointments and other procedures for which you are due. Text messaging is optional, so you may opt out at any time.

Other electronic communication: We may securely send or receive messages through the Patient Portal. We do not use email to communicate with individual patients or receive messages from them.

Treatment alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Fundraising: Some patients may receive letters requesting donations to Grace Health. If you do not want to be on that mailing list, you may contact us by phone or mail.

Emergency situations: In the case of a medical emergency, your information may be disclosed without obtaining a signed authorization to prevent delays in treatment. We may not be able to honor any normal restrictions on use or disclosure if emergency treatment is required. We may notify your family members, caregivers, and/or close friends in case of a medical emergency or if you are incapacitated. We may also share information that relates to their involvement in your health care based on our professional judgment if we determine it is in your best interest.

Disclosures permitted by law: We may disclose information about you without your permission if permitted or required by law. This includes the following situations:

- Immunization records – Immunization records will be reported to the Michigan Care Improvement Registry (MCIR).

(over)

- Public health authorities – We will disclose information to your county health department if you have one of the communicable diseases that must be reported under Michigan law. Information may be reported to state or federal agencies regarding preventing or controlling disease, workplace injuries and adverse events related to food or medical products.
- Controlled substance reports – If our pharmacy dispenses a controlled substance, we will report all details of the prescription and your government-issued ID to the State of Michigan.
- Court order – We will release any information requested in a court order or a subpoena issued by an official of the courts.
- Minor's confidential information – If you are a minor seeking your own care as allowed by law, we may contact your parents with information about your condition if it is determined medically necessary by a health care provider. Your parents may also become aware of the treatment if they are responsible for payment for the services.
- Abuse or neglect – We will report cases of suspected abuse or neglect to Child Protective Services or Adult Protective Services as required by law.
- Domestic abuse – We will report cases of domestic abuse to the authorities as required by law.
- Law enforcement – We may release information to law enforcement as needed to avert a serious health or safety threat or to locate a suspect, fugitive, material witness or missing person. We may release information to law enforcement for investigation of illegal activities involving controlled substances.
- Dental records – Dental records may be released to law enforcement to identify a deceased or missing person.
- Deceased patients – Information about deceased patients may be disclosed to the medical examiner, funeral director or an institutional review board such as the Fetal Infant Mortality Review.

Integrated Health Partners (IHP): We are a member of this hospital physician organization whose activities include medical insurance support, quality improvement and a community collaborative for chronic disease and case management. Your information may be shared with the IHP staff and partnering providers for those purposes.

Health Information Exchange: Other healthcare organizations providing care for you and clinical record extract services providing information to your insurance company may be able to view your health records electronically. Contact our Privacy Officer if you wish to opt out from this electronic exchange.

Video Recording: With your signed consent, your medical appointment with a resident may be recorded for educational purposes.

Other uses and disclosures: We will obtain written authorization from you or your legal representative for any uses or disclosures that are not described above, are not permitted by law or are not related to treatment, payment or health care operations. You may revoke a previously made authorization by providing written notice.

Notification of breaches: We will make every effort to protect the privacy of your health information. We will notify you by mail about a breach of confidentiality.

Patient rights

You have the following rights regarding your health records:

- Right to request restrictions on uses or disclosures – You have the right to request that we place limitations on our use or disclosure of your patient information. We have the right to choose not to agree to the requested restriction.
- Right to receive confidential communications – You have the right to request that we use alternative methods to contact you. We have the right to choose not to agree to the request.
- Right to inspect and copy – You have the right to make an appointment to review your health records. You may also request to receive a copy of your records at a reasonable fee. You may request that the records be provided in electronic format.
- Right to amend – You have the right to add a written statement to your records to clarify or correct the information within your medical or dental chart.
- Right to receive an accounting of disclosures – You have the right to request a list of all disclosures made without your written authorization that were not made for the purposes of treatment, payment or health care operations.
- Right to restrict disclosures to health plan – If you pay in full for services, you can request that information about those visits is not provided to your health insurance plan.

Changes to this notice

We reserve the right to revise this notice when there has been a material change in our privacy practices. We will abide by the terms of the notice currently in effect. The current version of the notice will be posted at Grace Health and on our website at www.gracehealthmi.org. You may contact us to receive a written copy.

Questions or complaints

If you have questions about this notice or Grace Health's privacy practices, please contact our Privacy Officer at (269) 965-8866. If you believe your privacy rights have been violated, you may contact our Privacy Officer. You may also file a written complaint with the Department of Health and Human Services. You will not be retaliated against for filing a complaint.