

MICHIGAN MEDICINE

Regional Alliance for Healthy Schools (RAHS)

Welcome Letter - School Based Health Center

NOT A MEDICAL RECORD DOCUMENT

Dear Student/Parent or Guardian:

Regional Alliance for Healthy Schools (RAHS) is a group of unique school-based health centers providing services at some public and community schools in Genesee and Washtenaw counties. The goal of the RAHS School-Based Health Centers is to help improve the health and well-being of students and families. Healthy students are more successful in school.

What is the RAHS School-Based Health Center?

- Our health centers are staffed by physicians, nurse practitioners, social workers and dietitians that are available for your physical and mental health needs.
- The purpose of this program is to provide quality healthcare in a friendly setting, at a time that is convenient to students and families. The RAHS Health Center is NOT trying to replace your regular source of healthcare.
- The RAHS Health Center is open and available to ALL youth.

What can I do to register?

- Please fill out the attached forms and return them to your school office or to the RAHS Health Center. The enclosed forms include:
 - Consent Forms
 - Health History Questionnaire
 - We also need a copy of the student's health insurance card

What happens after I register?

- By completing the enclosed forms, the student may be seen at the RAHS Health Center during the school day for health concerns and will be called down for a brief screening visit to obtain basic health information.
- If your child is in elementary school we ask that a parent/guardian be available by phone if you are unable to attend the appointment with your child.
- The RAHS Health Center will bill your insurance company for services received in our centers.
- If your child attends Mitchell Elementary school your child will receive services at the RAHS Mitchell Elementary Health Center, but has the option to receive services at our RAHS Scarlett Health Center.

How is private health information shared?

Please visit the Michigan Medicine Notice of Privacy Practices website here <http://www.med.umich.edu/hipaa/UMHS-NPPenglish.pdf> or ask at the RAHS Health Center for a copy of our privacy policy. This notice describes how medical information may be shared. Please review it carefully.

Thank you,

Pathways to Success Academic Campus

2800 Stone School Rd. Rm. 112
Ann Arbor, MI 48104
Phone: 734 973 9167

Lincoln High School

7425 Willis Rd. Rm. P114
Ypsilanti, MI 48197
Phone: 734 714 9600

Richfield Public School Academy

3807 North Center Road
Flint, MI 48506
Phone: 810-285-9815

Carman-Ainsworth High School

1300 N. Linden Road
Flint, MI 48532

Scarlett Middle School

3300 Lorraine, Rm. 204
Ann Arbor, MI 48108
Phone: 734 677 2708

Ypsilanti Community Middle School

235 Spencer Lane, Rm. 301
Ypsilanti, MI 48198
Phone: 734 221 2271

Northwestern High School

G-2138 West Carpenter Road
Flint, MI 48505
Phone: 810-760-5076

Kearsley High School

4302 Underhill Drive
Flint, MI 48506

Lincoln Middle School

8744 Whittaker Rd. Rm. 812
Ypsilanti, MI 48197
Phone: 734 714 9509

Ypsilanti Community High School

2095 Packard Rd. Rm. 403
Ypsilanti, MI 48197
Phone: 734 221 1007

Beecher High School

6655 Neff Road
Mt Morris, MI 48458
Phone: 810-591-9333

<p>MICHIGAN MEDICINE</p> <p>Regional Alliance for Healthy Schools (RAHS)</p> <p>General Consent For Healthcare Services, Assignment of Medical Benefits & Notice of Privacy Practices Acknowledgment</p>	<p>MRN: _____</p> <p>NAME: _____</p> <p>BIRTHDATE: _____</p> <p>CSN: _____</p> <p style="text-align: center;">FOR OFFICE USE ONLY</p>
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Please fill out Patient Information:

Last Name: _____ First: _____ Middle: _____

Date of Birth (mm/dd/yyyy): ____/____/____

General Consent for Healthcare Services

Medical services require a signed consent before services are provided. The following services are available:

- Physical exams
- Health education/risk prevention counseling
- Diagnosis and Management of acute and chronic illnesses/diseases
- Individual, group, family psychotherapy
- Immunizations
- Crisis intervention
- Dental and vision screenings
- Referral for substance abuse treatment (middle and high school students only)
- Basic laboratory tests including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin
- Referral for resources such as food, shelter, financial issues, transportation
- Venipuncture (Blood draws)
- Health Education or Activity Groups such as Walking Club, Nutrition Education, Anger Management, Asthma Program, Peer Mentoring, Mood and Movement, Youth Advisory Council, Bully Busters, and other groups as determined by need (some programs available to middle and high school students only)

Crisis interventions and emergency care do not require consent. Life-saving interventions MAY be initiated without prior consent. Services NOT provided at RAHS School Based Health Centers include dispensing contraception, abortion counseling, and long term psychotherapy.


We would like to be your partner in the care of your child. Please note that under Michigan law, there are some medical care services that your child can have without your permission (consent) or your knowledge.

Current Michigan Law mandates (requires) confidential services to minors in these areas: pregnancy, sexually transmitted infections (STI) and human immunodeficiency virus (HIV) testing and counseling.

I understand that under Michigan State law, in the event that a healthcare professional from the school based health center is exposed to blood or bodily fluids from a patient, testing (including HIV/AIDS) may be performed on a patient without consent.

I understand all **RAHS medical records** are part of Michigan Medicine electronic medical records system.

I understand RAHS School Based Health Center will use the patient's information as necessary to coordinate services at the school and for payment of services as outlined in the notice of privacy practices.

31-10122	VER: A/17 HIM: 03/17	Medical Record		General Consent For Healthcare Services, Assignment of Medical Benefits & Notice of Privacy Practices Acknowledgment
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NOTE: Image ALL PAGES or send ALL PAGES to Health Information Management – including pages without a signature section

**General Consent For Healthcare Services,
Assignment of Medical Benefits & Notice of
Privacy Practices Acknowledgment**

MRN:

FOR OFFICE
USE ONLY

NAME:

BIRTHDATE:

CSN:

Assignment of Medical Benefits

Except as barred by any agreement between my insurance company and Michigan Medicine or by state or federal law, I understand that I will be responsible for my co-payments, deductibles or other charges for medical services not covered or paid by insurance or other third party payers. I assign all rights and benefits to Michigan Medicine in order to facilitate reimbursement for health care services. I will help Michigan Medicine follow up on these claims.

Notice of Privacy Practices Acknowledgement (Check only ONE):


- I have been notified that the Michigan Medicine Notice of Privacy Practices is available at a RAHS Health Center upon my request. I know I can view it on-line at <http://www.med.umich.edu/hipaa/pdf/npp-summary.pdf>
- I would like to receive my copy of the Michigan Medicine Notice of Privacy Practices via **US. Mail**.
- I would like to receive my copy of Michigan Medicine Notice of Privacy Practices via e-mail at my **e-mail** address:
_____. I understand that if the e-mail fails, I will receive a copy of the notice via U.S. mail.

If my child is in elementary school, I understand this consent will remain valid until my child enters middle school. I will be asked to complete another consent if there is RAHS School Based Health System available at my child's new school. If the patient is in middle or high school, this consent will remain valid until the patient graduates. I may withdraw my consent for services by writing to the RAHS School Based Health Center at any time.

I am the patient (18 years or older) or legally authorized representative of the child listed above. I have reviewed and understand the services offered. I give consent to receive the services explained above.

Signature of Patient or Legally Authorized Representative (if patient is a minor or unable to sign) Date (mm/dd/yyyy)

Printed Name of Legally Authorized Representative (if patient is a minor or unable to sign)
Relationship: Parent Legal Guardian DPOA for Healthcare

31-10122	VER: A/17 HIM: 03/17	Medical Record		General Consent For Healthcare Services, Assignment of Medical Benefits & Notice of Privacy Practices Acknowledgment
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<p>MICHIGAN MEDICINE</p> <p>Regional Alliance for Healthy Schools (RAHS)</p> <p>Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS) – 18 Years of Age and Older</p>	<p>MRN: _____</p> <p>NAME: _____</p> <p>BIRTHDATE: _____</p> <p>CSN: _____</p>
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FOR OFFICE
USE ONLY

To register for the Regional Alliance for Healthy Schools Service please fill out this Health History Questionnaire form.

Today's Date: ____/____/____ School: _____ Grade: _____
(mm/dd/yyyy)

Student's Name: _____
Last First

Date of Birth: ____/____/____ Primary Language spoken in home _____ Needs Interpreter? Yes No
(mm/dd/yyyy)

What name do you like to use? _____ Gender: Male Female

Your email: _____ Your cell number: _____

Address: _____ Apt#: _____

City: _____ State: _____ Zip: _____

Providing the following information about ethnic group is strictly voluntary on your part and is not required to register.

Ethnic Group: American Indian African American Hispanic Caucasian Asian Middle Eastern
 Multi-racial (please specify): _____
 Other (please specify): _____

Emergency Contact Information

Contact Name: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Relationship to student: _____ Email: _____

Best way to reach the contact during the school day? Home Cell Work Email Other (specify): _____

Additional contact name:
Name: _____ Relationship to student: _____ Phone Number: _____

Do you have health insurance? No Yes

Insurance Name (specify): _____

Subscribers Name: _____ Subscriber's date of birth (DOB): ____/____/____
(mm/dd/yyyy)

Policy #: _____ Group # _____

Do you have a Primary Care Provider (PCP)? Yes No Name of PCP: _____

Date of last complete physical exam: _____

Do you have a Dentist? Yes No Name of Dentist: _____

Date last seen: _____ (mm/dd/yyyy) Was this a routine check-up? Yes No

Does your family have a preferred pharmacy? Name: _____ Phone/location: _____

Who lives in your home?

Name: _____	Relationship: _____
_____	_____
_____	_____
_____	_____

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Medications: I do not take any medications

Name of medicine:	Dose:	Reason for taking:	How long?	Prescribed by:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Allergies: Do you have any allergies to medicine, food, insect stings, bites or seasonal allergies? No Yes (please check and list below):

Medical Problems: Please check all that apply:

- Asthma Seizures/Epilepsy Depression Diabetes ADD/ADHD (Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder)
- Heart Problems Hay Fever/Allergies Learning Disability Anxiety
- Other (specify): _____

Do you wear any of the following (check all that apply)? eyeglasses contacts hearing device

Have you ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type of surgery?

No Yes: If yes, what age? _____ Problem/Type of Surgery? _____

Family History:

Some health problems are passed from one generation to the next. Have you or any blood relatives (parents, grandparents, brothers or sisters), living or deceased, had any of the following problems?

Unknown family history.

	Yes	No	Unsure	Relationship
Allergies/asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack or stroke <i>before</i> age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mental illness/Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Migraine headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Others (specify): _____				_____

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	Yes	No
1. Would you like to schedule an appointment with our Nurse Practitioner or Physician to discuss any health concerns?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have questions or concerns about your weight or eating habits? Please explain: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Would you like information from our staff regarding: <ul style="list-style-type: none"> • Finding a health care provider (doctor or nurse practitioner)? • Finding a dentist? • Affordable vision care or glasses? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
4. Would you like to be contacted by our therapist to discuss your child’s emotional well-being or concerns? <input type="checkbox"/> My child is already receiving services from a mental health professional.	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you concerned about you or your family’s income meeting your basic needs? <ul style="list-style-type: none"> • Do you need additional food? • Do you need additional clothing? • Do you need help paying bills for heat and water? • Do you need assistance with transportation to medical or school appointments? • Are you concerned about housing? 	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
6. Would you like information regarding: <ul style="list-style-type: none"> • Health Insurance? 	<input type="checkbox"/>	<input type="checkbox"/>

If you answered Yes to any of questions in 1-6 above, a member of our staff will contact you.

Thank You.

Printed name of person who completed this form

____/____/_____
Date (mm/dd/yyyy)

OFFICE USE ONLY:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Pathways to Success Academic Campus <input type="checkbox"/> Lincoln Middle School <input type="checkbox"/> Lincoln High School <input type="checkbox"/> Mitchell Elementary School | <ul style="list-style-type: none"> <input type="checkbox"/> Scarlett Middle School <input type="checkbox"/> Ypsilanti Community Middle School <input type="checkbox"/> Ypsilanti Community High School <input type="checkbox"/> Other (specify): _____ |
|---|--|