UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

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 unique school-based health centers providing services at some public and community schools in southeastern Michigan. The goal of the Regional Alliance for Healthy Schools (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 friendly setting, at a time that is convenient to the student and family. 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 or has the option to receive services at our RAHS Scarlett Health Center.

How is private health information shared?

Please visit UMHS Notice of Privacy Practices Website Address:
http://www.med.umich.edu/hipaa/UMHS-NPPenglish.pdf or ask at the RAHS Health Center for a copy.
This notice describes how medical information may be shared. Please review it carefully.

Thank you,

Select from dropdown list or type

Pathways to Success Academic Campus
2800 Stone School Rd. Rm. 112
Ann Arbor, MI 48104
Phone: 734 973 9167

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

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

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

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

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

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS Regional Alliance for Healthy Schools (RAHS) **General Consent For Healthcare Services, Assignment of Medical Benefits & Notice of Privacy Practices Acknowledgment**	MRN: NAME: BIRTHDATE: CSN: FOR OFFICE USE ONLY

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
- Diagnosis and Management of acute and chronic illnesses/diseases
- Immunizations
- Dental and vision screenings
- Basic laboratory tests including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin
- Health education/risk prevention counseling
- Individual, group, family psychotherapy
- Crisis intervention
- Referral for substance abuse treatment (middle and high school students only)
- 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) <u>confidential services</u> 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 the UMHS 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.

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Assignment of Medical Benefits

Except as barred by any agreement between my insurance company and University of Michigan Hospitals and Health Centers (UMHHC) 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 UMHHC in order to facilitate reimbursement for health care services. I will help UMHHC follow up on these claims.

Notice of Privacy Practices Acknowledgement (Check only ONE):

- ❑ I have been notified that the UMHS 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 UMHS Notice of Privacy Practices via **US. Mail**.
- ❑ I would like to receive my copy of the UMHS 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/14 HIM: 08/14	Medical Record		General Consent For Healthcare Services, Assignment of Medical Benefits & Notice of Privacy Practices Acknowledgment

NOTE: Image ALL PAGES or send ALL PAGES to Health Information Management – including pages without a signature section

UNIVERSITY OF MICHIGAN HOSPITALS & HEALTH CENTERS

Regional Alliance for Healthy Schools (RAHS)

Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS)

MRN:

NAME:

BIRTHDATE:

CSN:

FOR OFFICE USE ONLY

To register your child (or adolescent) for the Regional Alliance for Healthy Schools Service please fill out this Health History Questionnaire form.

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

Child's Name: _____ _____
Last First

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

What name does your child like to use? _____ Gender: ❑Male ❑Female

Patient's email: _____ Patient's 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 your child.

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

❑Other (please specify): _____

Parent / Guardian Name (if child is under 18):_____

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

Email: _____

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

Emergency Contact Name (if parent not available):

Relationship to student: _____ Phone Number: _____

Do you have health insurance? ❑No ❑Yes

Insurance Name: _____

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

Policy #: _____ Group # _____

Does your child have a Primary Care Provider (PCP)? ❑Yes ❑No Name of PCP: _____

Date of last complete physical exam: _____

Does your child have a Dentist? ❑Yes ❑No Name of Dentist: _____

Date last seen: _____ Was this a routine check-up? ❑Yes ❑No

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

Who lives in the home?

Name:	Relationship:

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Medications: ❑My child does not take any medications

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

_____

_____

_____

_____

Allergies: Does your child have any allergies to medicine, food, insect stings, bites or seasonal allergies? ❑No ❑Yes (please list below):

_____

_____

_____

Medical Problems: Please check all that apply for your child.

❑Asthma ❑Depression ❑Learning Disability ❑Diabetes ❑Heart Problems

❑Anxiety ❑Seizures/Epilepsy ❑ADD/ADHD (Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder)

❑Other (specify): _____

Does your child wear any of the following (check all that apply)? ❑eyeglasses ❑contacts ❑hearing device

Has your child 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 or your adolescent's blood relatives (parents, grandparents, brothers or sisters), living or deceased, had any of the following problems?

☐ Unknown family history. ☐ Adopted

☐ I was adopted so I do not know my family history.

	Yes	No	Unsure	Relationship
Allergies/asthma	❑	❑	❑	_____
Cancer (type: _____)	❑	❑	❑	_____
Depression	❑	❑	❑	_____
Diabetes	❑	❑	❑	_____
Heart attack or stroke *before* age 50	❑	❑	❑	_____
High blood pressure	❑	❑	❑	_____
High cholesterol	❑	❑	❑	_____
Mental illness/Depression	❑	❑	❑	_____
Migraine headaches	❑	❑	❑	_____
Smoking	❑	❑	❑	_____
Substance Abuse	❑	❑	❑	_____

Others (specify): _____

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	Yes	No
1. Would you like to schedule an appointment for your child with our Nurse Practitioner or Physician to discuss any health concerns?	☐	☐
2. Do you have questions or concerns about your child's weight or eating habits? Please explain: _____	☐	☐
3. Would you like information from our staff regarding:		
• Finding a health care provider (doctor or nurse practitioner)?	☐	☐
• Finding a dentist?	☐	☐
• Affordable vision care or glasses for your child?	☐	☐
4. Would you like to be contacted by our therapist to discuss your child's emotional well-being or concerns? ☐ My child is already receiving services from a mental health professional.	☐	☐
5. Are you concerned about your income meeting the basic needs of your family?	☐	☐
• Do you need additional food for your family?	☐	☐
• Do you need additional clothing for your family?	☐	☐
• 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 for your family?	☐	☐
6. Would you like information regarding:		
• Health Insurance?	☐	☐

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:

- ❑ **Pathways to Success Academic Campus**
- ❑ **Lincoln Middle School**
- ❑ **Lincoln High School**
- ❑ **Mitchell Elementary School**
- ❑ **Scarlett Middle School**
- ❑ **Ypsilanti Community Middle School**
- ❑ **Ypsilanti Community High School**
- ❑ **Other (specify):**

_____