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, Jackson, 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 behavioral 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.

How is private health information shared?
Please visit the Michigan Medicine Notice of Privacy Practices website here http://www.med.umich.edu/hipaa/UMHS-NPENGLISH.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,
Regional Alliance for Healthy Schools Clinical Team

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. 304
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
Phone: 810-591-5473

Brick Elementary School
8970 Whittaker Road
Ypsilanti, MI 48197
Phone: 734-714-9606

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

Ypsilanti Community Middle School
510 Emeric
Ypsilanti, MI 48198
Phone: 734 221 2271

Kearsley High School
4302 Underhill Drive
Flint, MI 48506
Phone: 810-591-5330

Armstrong Middle School
6161 Hopkins Road
Flint, MI 48506
Phone: 810-591-2776

International Academy of Flint
2820 S. Saginaw Street
Flint, MI 48503
Phone: 810-600-5290

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
6255 Neff Road
Mt Morris, MI 48458
Phone: 810-591-9333

Pioneer High School
601 W. Stadium Blvd.
Ann Arbor, MI 48103
Phone: 734-997-1862

Springport Public Schools
300 W. Main Street
Springport, MI 49284
1. **What services does the Regional Alliance for Healthy Schools at Michigan Medicine provide?**

- Physical exams
- Health education/Risk prevention counseling
- Individual, group and family psychotherapy
- Crisis intervention
- Referral for substance abuse treatment (Middle and high school students)
- Referral for resources such as food, shelter, financial issues, transportation.
- Health education or Activities Group 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)
- Diagnosis and management of acute and chronic illnesses/diseases
- Immunizations
- Dental and vision screenings
- Basic laboratory test including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin
- Venipuncture (blood draws).

2. **Why might the Michigan Medicine use my specimens for research?**

Medical research is constantly discovering new ways to identify, prevent and treat illness. Michigan Medicine is committed to advancing research so we can provide our patients with the most effective medical care.

3. **Can I consent to only part of this form?**

Yes, a patient has the right to cross out sections of the consent they do not want to consent to.

4. **Can I withdraw my consent or my child’s consent after this form has been signed?**

Yes, you may withdraw consent for services by writing to the Regional Alliance for Healthy Schools Based Health center at any time.

**To withdraw from all Michigan Medicine service please mail a letter signed by parent or guardian for minor or the patient for patients 18 and over to:**

Michigan Medicine, Revenue Cycle Mid Service (HIM), Release of Information (ROI) Unit, 3621 S. State Street 700 KMS Place, Bay 11 - Mid Service, Ann Arbor MI 48108-1633, Fax: 734-936-8571 or call 734-936-5490.
Notice of Privacy Practices (NPP) Acknowledgement:
I hereby acknowledge I have been offered or received the Michigan Medicine Notice of Privacy Practices.

General Consent to Receive Health Care Services
I want to receive health care services from Michigan Medicine including medical, dental, psychological, nursing and/or other health care. Services may include:

- Surgeries and procedures
- Medications
- Immunizations
- Tests
- Telemedicine Services
- Other treatment necessary for my care

I agree that Michigan Medicine can share my information as needed for care or billing and that various departments may contact me. To facilitate my care and medical needs, Michigan Medicine departments may need to provide necessary information about me to other outside healthcare providers. I have a right to discuss my health care with my health care providers at any time. I have the right to agree to or refuse any care. I understand that my health care providers generally will obtain my consent after discussing specific care, therapies and procedures with me. My health care providers will review known risks, expected benefits and alternatives to therapies in those discussions. I may need to give additional consents for invasive procedures and special treatments such as when I receive blood products. I understand that the practice of medicine is uncertain. It is impossible to avoid certain risks and clinical outcomes may be different for each patient.

Assignment of Medical Benefits
I agree 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. This is true except in cases where Michigan or federal law, or an agreement between my insurance company and Michigan Medicine does not allow it. I assign all rights and benefits to Michigan Medicine in order to help the process of paying Michigan Medicine for health care services I received. I agree to help Michigan Medicine follow up on these claims.

Important Patient Information

1. **Michigan Medicine is a Teaching and Research Center.** I may receive services from staff and/or trainees chosen and overseen by the teaching staff. Trainees and teachers may read and use my health care records for teaching and research. I agree to donate any excess tissues, specimens or parts of organs that are removed from my body during testing or medical procedures and are not necessary for my diagnosis or treatment. I authorize Michigan Medicine to own, use, retain, preserve, manipulate, analyze or dispose of this excess tissue. Michigan Medicine may use or retransfer these items to any entity for any lawful purpose, including education and research. Furthermore, I understand that it is possible that a treatment or test that I receive may have been developed by my physician and that he/she may financially benefit from royalty payments accruing from the use of such a test or treatment which has previously been properly vetted through regulatory channels in accordance with state and federal law. I understand that I am able to ask my doctor if an invention of his/hers will be used in my care.

2. **Human Immunodeficiency Virus (HIV) is the virus that causes AIDS (Acquired Immune Deficiency Syndrome). Under Michigan law, an HIV test may be done on a patient** if any health care worker or emergency responder comes in contact with that patient’s blood or other body fluids. Contact may occur under the skin, in an open wound or through the mucous membranes, which are the tissues that line various openings in the body. If this type of contact occurs, I know that my blood can be tested without my consent. If a test is done, I know that I will receive the test results and counseling as needed.
3. Communication Methods. Michigan Medicine uses many ways to communicate with me. The method used will depend on the reason or reasons for the communication. By providing Michigan Medicine with my contact information I agree to receive communications in different methods, for example: automated calls, text messaging, patient portal, emails, etc. I further agree that Michigan Medicine can send me text messages more than three (3) times a week. I understand that I can choose not to participate in some or all of these methods, but I must communicate my wishes to staff. Michigan Medicine may record incoming and outgoing phone calls with me for quality assurance and training purposes.

4. Telemedicine Services. I understand that I may receive care through telemedicine services. The limitations of a telemedicine visit include the possibility of not being able to pick up conditions found during a complete physical exam. There may also be technical difficulties like a lost connection or interruption.

5. Safety and Security. In the interest of patient, staff and visitor safety, Michigan Medicine reserves the right to inspect or prohibit the use of personally owned devices and equipment including, but not limited to cell phones (including camera and video functions). Smoking and the use of tobacco products and non FDA-approved marijuana products is not allowed in Michigan Medicine facilities. This includes marijuana, non FDA-approved medical marijuana products in all forms, tobacco cigarettes, chewing tobacco and e-cigarettes. Facilities include buildings, grounds, parking lots and inside personal vehicles on Michigan Medicine property. Michigan Medicine is not responsible for loss or theft of any personal property if not placed in a Michigan Medicine-provided safe or secure area.

6. Photographing or Recording Done by or Arranged by Patients/Families. Patients, their families, and their friends are not guaranteed a right to photograph or record on Michigan Medicine premises. However, photographing or recording may be permitted using their own devices subject to the following guidelines: 1. Photographing or recording must stop right away if directed to do so by Michigan Medicine staff or at any time if it interferes with clinical care or service to patients, patient privacy, security or operations; 2. Families or visitors of a patient may only photograph or record the patient; 3. Patients and visitors may not include other patients or Michigan Medicine faculty or staff without their verbal permission; 4. Photographs and recordings taken by the family or visitors may not be entered into the medical record.

7. Advance Directives. I understand I can create an advance directive to identify a person I choose to make decisions for me if I am unable to make decisions or communicate my wishes about my care.

My signature represents the following (check all that apply):

- [ ] Acknowledgement of NPP Notification
- [ ] General Consent to Receive Healthcare Services
- [ ] Assignment of Medical Benefits agreement

I have read and understand the information on this form before I signed it.

____________________________          _____/_____/________
Signature of Patient or Legally Authorized Representative (If patient is unable to sign)  Date (mm/dd/yyyy)

____________________________          _______ A.M. / P.M.
Printed Name of Legally Authorized Representative (If patient is unable to sign)  Time:
Relationship:  Spouse  Next-of-Kin  Legal Guardian  DPOA for HealthCare
To register for the Regional Alliance for Healthy Schools Service please fill out this Health History Questionnaire form.

Today's Date: _____/_____/__________

School: __________________________________
Grade: _________________

Student's Name: ________________________________
(mm/dd/yyyy)

Last Name: ____________________________________
First Name: __________________________________

Date of Birth: _____/_____/_______

Primary Language spoken in home ____________
Needs Interpreter? ❑ Yes ❑ No

(mm/dd/yyyy)

Sex Assigned at Birth: ❑ Male ❑ Female

What name do you like to use? ____________________

Preferred Pronouns: she/her/hers he/him/his they/them/their

Your email: __________________________________

Address: ____________________________________

City: _________________________________________

Apt#: ________________________________________

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: __________________________

Name: __________________________

Relationship: __________________________

Name: __________________________

Relationship: __________________________

Name: __________________________

Relationship: __________________________

Name: __________________________

Relationship: __________________________
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.

<table>
<thead>
<tr>
<th>Family History</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies/asthma</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
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<tr>
<td>Cancer (type: ________________)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Depression</td>
<td>☐</td>
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<tr>
<td>Diabetes</td>
<td>☐</td>
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<tr>
<td>Heart attack or stroke before age 50</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>______________________</td>
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<tr>
<td>High blood pressure</td>
<td>☐</td>
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<tr>
<td>High cholesterol</td>
<td>☐</td>
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<tr>
<td>Mental illness/Depression</td>
<td>☐</td>
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<td>☐</td>
<td>______________________</td>
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<tr>
<td>Migraine headaches</td>
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<tr>
<td>Smoking</td>
<td>☐</td>
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<tr>
<td>Others (specify):</td>
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<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>1. Would you like to schedule an appointment with our Nurse Practitioner or Physician to discuss any health concerns?</td>
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<td>2. Do you have questions or concerns about your weight or eating habits?</td>
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<td>Please explain: ______________________________________________________</td>
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<tr>
<td>3. Would you like information from our staff regarding:</td>
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<tr>
<td>• Finding a health care provider (doctor or nurse practitioner)?</td>
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<td>☐</td>
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<td>• Finding a dentist?</td>
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<td>• Affordable vision care or glasses?</td>
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<td>4. Would you like to be contacted by our therapist to discuss your emotional well-being or concerns?</td>
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<td>☐ I am already receiving services from a mental health professional.</td>
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<td>5. Are you concerned about your family’s income meeting your basic needs?</td>
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<td>• Do you need additional food?</td>
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<td>• Do you need additional clothing?</td>
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<td>• Do you need help paying bills for heat and water?</td>
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<tr>
<td>• Do you need assistance with transportation to medical or school appointments?</td>
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<tr>
<td>• Are you concerned about housing?</td>
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<td>6. Would you like information regarding:</td>
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<tr>
<td>• Health Insurance?</td>
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</tbody>
</table>

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
- Richfield Public School Academy
- Carman-Ainsworth High School
- Pioneer High School
- Armstrong Middle School
- International Academy of Flint
- Scarlett Middle School
- Ypsilanti Community Middle School
- Ypsilanti Community High School
- Beecher High School
- Kearsley High School
- Bishop Elementary School
- Other (specify): ________________________________