Welcome Letter - School Based Health Center

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.
MICHIGAN MEDICINE
Regional Alliance for Healthy Schools (RAHS)

خطاب ترحيبي - مركز صحي مدرسي

Welcome Letter - School Based Health Center (Arabic)

كيف يتم تبادل المعلومات الصحية الخاصة؟

How is private health information shared?

برحى زيارة الموقع الإلكتروني الخاص بإشار ممارسات الخصوصية الخاصة به أرسل في مركز الصحي للحصول على نسخة من سياسة الخصوصية RAHS الخاصة بهذا. يرجى مراجعة هذه الإشاع أصعب، يمكن مشاركة المعلومات المحلية، يرجى مراجعته بعناية.

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.

شكراً,
Thank you,

الفريق السريري للتحالف الإقليمي للمدارس الصحية

Regional Alliance for Healthy Schools Clinical Team

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

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

Beecher High School
6255 Neff Road
Mt. Morris, MI 48458
810-591-9333
Phone: 810-591-9333

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

Springport Public Schools
300 W. Main Street
Springport, MI 49284

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

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

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

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

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

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

Richfield Public School Academy
3807 North Center Road
Flint, MI 48506
810-285-9815
Phone: 810-285-9815

Carman-Ainsworth High School
1300 N. Linden Road
Flint, MI 48532
810-591-5473
Phone: 810-591-5473

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

NOT A MEDICAL RECORD DOCUMENT

Page 1 of 2
Michigan Medicine
Regional Alliance for Healthy Schools (RAHS)

Frequently Asked Questions About the General Treatment Consent Form (Arabic)

1. What services does the Regional Alliance for Healthy Schools at Michigan Medicine provide?

- Diagnosis and management of acute and chronic illnesses/diseases
- Physical exams
- Immunizations
- Dental and vision screenings
- Basic laboratory test including urinalysis, glucose, rapid strep test, cholesterol, hemoglobin
- Venipuncture (blood draws)
- Referral for resources such as food, shelter, financial issues, transportation
- Asthma, Anger Management, Nutrition Education, Walking Club, Bully Busters, Youth Advisory Council, Mood and Movement, Peer Mentoring, Program

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

To discover new methods to identify, prevent, and treat diseases. Michigan Medicine is committed to advancing research so we can provide 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 Acknowledgment (NPP):
I hereby acknowledge I have been offered or received the Michigan Medicine Notice of Privacy Practices:

I, as the parent/guardian, want my child to receive health care services from Michigan Medicine including medical, dental, psychological, nursing and/or other health care. Services may include:

- Surgeries and procedures
- Telemedicine services
- Immunizations
- Medications
- Tests
- A[other treatment necessary for my child's care.]

I agree that Michigan Medicine can share my child’s information as needed for care or billing and that various departments may contact me. To facilitate my child’s care and medical needs, Michigan Medicine departments may need to provide necessary information about my child to other outside healthcare providers. I have a right to discuss my child’s health care with my child’s health care providers at any time. I have the right to agree to or refuse any care. I understand that my child’s health care providers generally will obtain my consent after discussing specific care, therapies and procedures with me. My child’s 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 my child receives 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 child’s 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 child’s insurance company and Michigan Medicine does not allow it. I assign all rights and benefits to

I hereby acknowledge I have been offered or received the Michigan Medicine Notice of Privacy Practices.

General Consent for Healthcare Services and Important Patient Information – CHILD (Arabic)

Eshgar mabtalam almarmasat alkhasousiyah:
"Amar ba'an kad tam'tiha o talil 'Eshgar Tab Mitishijan lam Marmasat alkhasousiyah." li:
Ana biskfini 'Adam alwa'di'in/uswisi, arbag ba'hsoul 'Telifi 'ala 'xamat alr'ayaa al-alfiah 'min 'Tab Mitishijan" bima fa 'llalk r'ayaa atibiyah 'wa 'xamat
Tab al-anasin 'wa alr'ayaa atibiyah 'wa 'ahdari 'wa 'ayrigha 'ana 'ashkar alr'ayaa al-alfiah 'alaihi. Wad 'anettimnha 'hiz fal 'xamat na ml 'A

I hereby acknowledge I have been offered or received the Michigan Medicine Notice of Privacy Practices:

General Consent to Receive Health Care Services

I, as the parent/guardian, want my child to receive health care services from Michigan Medicine including medical, dental, psychological, nursing and/or other health care. Services may include:

- Surgeries and procedures
- Telemedicine services
- Immunizations
- Medications
- Tests
- Other treatment necessary for my child's care.

I agree that Michigan Medicine can share my child’s information as needed for care or billing and that various departments may contact me. To facilitate my child’s care and medical needs, Michigan Medicine departments may need to provide necessary information about my child to other outside healthcare providers. I have a right to discuss my child’s health care with my child’s health care providers at any time. I have the right to agree to or refuse any care. I understand that my child’s health care providers generally will obtain my consent after discussing specific care, therapies and procedures with me. My child’s 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 my child receives 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 child’s 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 child’s insurance company and Michigan Medicine does not allow it. I assign all rights and benefits to
Important Patient Information

1. Michigan Medicine is a Teaching and Research Center. My child may receive services from staff and/or trainees chosen and overseen by the teaching staff. Trainees and teachers may read and use my child’s health care records for teaching and research. I agree to donate any excess tissues, specimens or parts of organs that are removed from my child’s body during testing or medical procedures and are not necessary for my child’s 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 my child received may have been developed by my child’s 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 child’s doctor if an invention of his/hers will be used in my child’s 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 child’s blood can be tested without my consent. If a test is done, I know that my child will receive the test results and counseling as needed.
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.

Telemedicine Services. I understand that my child 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.

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.

The photograph or image that accompanies the consent form is intended for Michigan Medicine's use only. It is not to be shared with anyone who is not authorized by Michigan Medicine to see this information.
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.

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.

____________/_______/_______
Date (mm/dd/yyyy)  Signature of Patient or Legally Authorized Representative

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

________________________
Printed Name of Legally Authorized Representative

____________ A.M. / P.M
Time:

Legal Guardian  Next-of-Kin  Parent  Relationship:
To register your child (or adolescent) for the Regional Alliance for Healthy Schools Service please fill out this Health History Questionnaire form.

**Child’s Name:** _________________________________

**Today’s Date:** _____/_____/__________  
**School:** _______________________________________

**Date of Birth:** ____/____/________  
**Primary Language spoken in home:** _______________________

**Gender Identity:** _______________________

**Sex Assigned at Birth:**  □ Male  □ Female  
**What name does your child like to use?** ___________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Address:** ______________________________________________ 
**City:** ______________________________________________ 
**Apt#:** _________________  
**State:** _______________  
**Zip:** __________________

**Age Range:** ______________________

**Patient’s email:** ______________________________ 
**Patient’s cell number:** ____________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Date of Birth:** ____/____/________  
**School:** _______________________________________

**Primary Language spoken in home:** _______________________

**Gender Identity:** _______________________

**Sex Assigned at Birth:**  □ Male  □ Female  
**What name does your child like to use?** ___________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Address:** ______________________________________________ 
**City:** ______________________________________________ 
**Apt#:** _________________  
**State:** _______________  
**Zip:** __________________

**Age Range:** ______________________

**Patient’s email:** ______________________________ 
**Patient’s cell number:** ____________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Date of Birth:** ____/____/________  
**School:** _______________________________________

**Primary Language spoken in home:** _______________________

**Gender Identity:** _______________________

**Sex Assigned at Birth:**  □ Male  □ Female  
**What name does your child like to use?** ___________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Address:** ______________________________________________ 
**City:** ______________________________________________ 
**Apt#:** _________________  
**State:** _______________  
**Zip:** __________________

**Age Range:** ______________________

**Patient’s email:** ______________________________ 
**Patient’s cell number:** ____________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Date of Birth:** ____/____/________  
**School:** _______________________________________

**Primary Language spoken in home:** _______________________

**Gender Identity:** _______________________

**Sex Assigned at Birth:**  □ Male  □ Female  
**What name does your child like to use?** ___________________________

**Parent / Guardian Date of Birth:** __________________________

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

**Address:** ______________________________________________ 
**City:** ______________________________________________ 
**Apt#:** _________________  
**State:** _______________  
**Zip:** __________________

**Age Range:** ______________________

**Patient’s email:** ______________________________ 
**Patient’s cell number:** ____________________________
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: __________________________

Subscriber’s 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: __________________________

Name: __________________________

Relationship: __________________________

Name: __________________________

Relationship: __________________________
МЕДИЦИНА МИЧИГАНА
Региональный союз здоровых школ (RAHS)

( RAHS )

استبيان التاريخ الصحي - التحالف الإقليمي للمدارس الصحية

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

الدواء: □ لا يأخذ أي أدوية
□ My child does not take any medications

المواصفة من قبل: □ ما هي المدة؟
□ Reason for taking:

اسم الدواء: □ الجرعة:
□ Dose:

سبب تناوله: □ How long?
□ Prescribed by:

الحساسية: □ لا
□ Yes (please list below):

أدوية: □ نعم
□ No

الحساسية: هل يعاني طفلك من أي حساسية تجاه الأدوية أو الطعام أو لسعات الحشرات أو الالتهابات الحساسية الموسمية؟ □ لا

Allergies: Does your child have any allergies to medicine, food, insect stings, bites or seasonal allergies?

نوع الحساسية: □ No
□ Yes: If yes, what age?

العينة: □ ما هو العمر؟

□ Other (specify): ________________________________________________

العوارض: □ هل يرتدي طفلك أيًا مما يلي (ضع علامة على كل ما ينطبق على طفلك).

□ Heart Problems

□ Other (specify):

□ Asthma

□ Depression

□ Learning Disability

□ Diabetes

□ Seizures/Epilepsy

□ ADD/ADHD (Attention Deficit Disorder / Attention Deficit Hyperactivity Disorder)

□ eyeglasses

□ contacts

□ hearing device

هل يرتدي طفلك من أيًا مما يلي (ضع علامة على كل ما ينطبق على طفلك)

هل يرتدي طفلك نظارة طبية؟ □ ما هو العمر؟

□ glasses

□ contacts

□ hearing device

هل سبق لطفلك دخول المستشفى لمدة ليلة، أو تعرض لأي إصابات خطيرة بما في ذلك الإصابات المرتبطة بالرياضة، أو خضع لأي نوع من الجراحة؟ □ لا

Has your child ever been hospitalized overnight, had any serious injuries including sports-related injuries, or had any type of surgery?

Problem/Type of Surgery?

□ No

□ Yes: If yes, what age? ___________________________
**Family History:**

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

<table>
<thead>
<tr>
<th>Health Problem</th>
<th>Yes</th>
<th>No</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies/asthma</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack or stroke before age 50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>High cholesterol</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental illness/Depression</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine headaches</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (specify):</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other health problems that may not be listed above:

Others (specify):
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:
   - Affordable vision care or glasses for your child?
   - 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? .................................................................

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.

Date (mm/dd/yyyy)

Printed name of person who completed this form

For 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):

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

شكرًا لك.

Date (اليوم/الشهر/السنة)

الاسم بالأحرف الواضحة للشخص الذي أكمل هذا النموذج

Printed name of person who completed this form

الاستخدام المكتبي فقط:

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):