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, 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, and social workers 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 patients 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 patient's health insurance card

What happens after I register?

- By completing the enclosed forms, patients 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 the patient is in elementary school, we ask that a parent/guardian be available by phone if they are unable to attend the appointment with their 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 https://www.uofmhealth.org/patients-visitors/patients/patient-privacy/notice-privacy-practices 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

Belleville High School
501 W.Columbia Ave.
Belleville, MI 48111
Phone: 734-697-1144

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
235 Spencer Lane
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
Phone: 517-867-7846

99-10073 HIM: 03/2026

MICHIGAN MEDICINE **Frequently Asked Questions About the General Treatment Consent Form**	MRN: NAME: BIRTHDATE: CSN:

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

- Physical exams
- Immunizations
- Individual, group and family psychotherapy
- Basic lab tests e.g. urinalysis, rapid strep, venipuncture
- HIV / STI services (e.g. screening, testing, counseling, etc.)
- Telemedicine services
- Referral for resources such as food, shelter, financial issues, transportation
- Health education
- Medications
- Behavioral health screening and management
- Diagnosis and management of acute and chronic illnesses/diseases
- Reproductive health services (e.g. birth control education, pregnancy testing)
- Minor-consented services
- Referral for substance abuse treatment (middle and high school student)
- Health education or Activities Group such as Walking Club, Anger Management, Asthma Program, Peer Mentoring, Youth Advisory Council, Bully Busters, or other groups as determined by need (some programs available to middle and high school students only)

1. **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.

2. **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.

3. **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.

MICHIGAN MEDICINE Regional Alliance for Healthy Schools (RAHS) **General Consent for Healthcare Services and Important Patient Information - CHILD**	MRN: NAME: BIRTHDATE: CSN: DOS:

Notice of Privacy Practices (NPP) Acknowledgment:

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:

- Physical exams, health education and Immunization
- Basic lab tests e.g. urinalysis, rapid strep, venipuncture
- Diagnosis and management of acute chronic illnesses/diseases
- HIV / STI services (e.g. screening, testing, counseling, etc)
- Reproductive health services (e.g. birth control education, pregnancy testing)
- Behavioral health screening and management
- Individual, group and family psychotherapy
- Medication
- Minor-consented services
- Telemedicine services
- Other treatment necessary for my 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. It is impossible to avoid certain risks in the practice of medicine. Outcomes may be different for each patient. I may withdraw consent for services by writing to the Regional Alliance for Healthy Schools health center at any time.

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 Michigan Medicine in order to help the process of paying Michigan Medicine for health care services my child received. I agree to help Michigan Medicine follow up on these claims.

Important Patient Information

1. **The Hospital 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 if they are not necessary for my child's diagnosis or treatment. I allow the Hospital to own, manipulate, analyze, keep, save or throw away this excess tissue. The Hospital may use or share these items with any entity for any legal purpose, including education and research. I understand that my child's doctor may have developed a treatment or test that my child is given. The treatment or test has been approved for use and it is allowed under state and federal law. My child's doctor may profit from the use of the test or treatment. 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.
3. **Communication Methods**. Michigan Medicine uses many ways to communicate with me/my child. 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 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.
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.

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 Parent or Legally Authorized Representative Date (mm/dd/yyyy)

_____Time: _____ A.M. / P.M.
Printed Name of Parent or Legally Authorized Representative
Relationship: ☐ Parent ☐ Next-of-Kin ☐ Legal Guardian

MICHIGAN MEDICINE 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)

Sex Assigned at Birth: ❑Male ❑Female What name does your child like to use? _____

Gender Identity: _____ Preferred Pronouns: she/her/hers he/him/his they/them/theirs

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): _____

Parent / Guardian Date of Birth: _____

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:
_____	_____
_____	_____
_____	_____
_____	_____

MICHIGAN MEDICINE Regional Alliance for Healthy Schools (RAHS) **Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS)**	MRN: NAME: BIRTHDATE: CSN:	FOR OFFICE USE ONLY

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

☐ Unknown family medical history. ☐ My child was adopted, family medical history is unknown

	Yes	No	Unsure	Relationship	Maternal or Paternal
Allergies	❑	❑	❑	_____	_____
Asthma	❑	❑	❑	_____	_____
Cancer (type: _____)	❑	❑	❑	_____	_____
Anxiety	❑	❑	❑	_____	_____
Bi-polar depression	❑	❑	❑	_____	_____
Depression	❑	❑	❑	_____	_____
Other mental illness	❑	❑	❑	_____	_____
Diabetes	❑	❑	❑	_____	_____
Heart attack or stroke *before* age 50	❑	❑	❑	_____	_____
High blood pressure	❑	❑	❑	_____	_____
High cholesterol	❑	❑	❑	_____	_____
Migraine headaches	❑	❑	❑	_____	_____
Smoking	❑	❑	❑	_____	_____
Substance Abuse	❑	❑	❑	_____	_____

Others (specify): _____

MICHIGAN MEDICINE Regional Alliance for Healthy Schools (RAHS) **Health History Questionnaire - Regional Alliance for Healthy Schools (RAHS)**	MRN: NAME: BIRTHDATE: CSN:	FOR OFFICE USE ONLY

	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)