Kalkaska
Phone 231.258.7791
(Fax) 231.258.7795
Open Monday through Friday

Teen Health Corner
419 S. Coral St.
Kalkaska, MI 49646

Forest Area
Phone 231.369.2000
(Fax) 231.369.2113
Open Monday/Wednesday/Thursday

Parental/Patient Consent Form

The Teen Health Corner is a health clinic for adolescents 10-21 years of age and their children. The Teen Health Corner in partnership with the Kalkaska Memorial Health Center promotes health and wellness for all area youth by providing medical care, counseling, assessment, and referral services. Assistance with Medicaid and MI Child enrollment is available for uninsured families. Prenatal (pregnancy) care and abortion counseling/referral will not be provided. Parental consent is required to receive most services. Teen Health Corner participates in the Michigan Care Improvement Registry's (MCIR).

Consent for Care

I have read this Parental Consent Form and understand the services offered through the Teen Health Corner. I give consent for my child, _____, _____, to receive health care services.

Print Patient Name **Date of Birth**

I understand that I may withdraw my consent at any time through written notification to the Teen Health Corner.
I understand that my consent will remain valid until otherwise notified. I authorize the Teen Health Corner to release information regarding treatment of the above-named child to third party payers or others for purposes of payment or services.

_____ _____ _____

Printed Name of Parent /Guardian **Signature of Parent/Guardian or Patient over 18** **Date**

HIPPA Privacy:

The Facility's Notice of Privacy Practices describes the specific meanings of 'treatment', 'payment', and 'health care operations' and how the Facility may use and disclose health information to carry out these functions. You are entitled to a copy of the Facility's Notice of Privacy Practices; call 231-258-7791 and one will be mailed to you. Please sign below for acknowledgement of notice of privacy practices (HIPPA).

_____ _____

Signature of Parent/Guardian or Patient over 18 **Date**

Transport (optional):

I agree to give my child permission to be transported to appointments by a Teen Health Corner employee to the clinic(s) and additional health services in the county. This permission can be revoked at any time.

_____ _____

Parent/Guardian Signature **Date**

Patient Information & Health History Questionnaire

Name:_____ DOB:_____

Address:_____

Street Number & Name City State Zip

Phone #:_____ ❑ Male ❑ Female Race:_____ Age:_____ Grade in School: _____

Parent/Guardian:_____ Daytime #:_____ Work #:_____ Cell #: _____

Emergency Contacts: 1._____ Phone #: _____

2._____ Phone #:_____

School_____Transportation to school: ❑ Bus ❑ Walk ❑ Parent ❑ Other_____

Do you have a family doctor or clinic? ❑ Yes ❑ No If Yes, Name & Phone #:_____

Do you have medical insurance? ❑ Yes ❑ No If Yes, complete the following: Subscriber Name: _____

Name of Insurance Company:_____ Address: _____

Phone #:_____ Contract #:_____ Group #: _____

Patient Medical History:

Are you allergic to anything? ❑ Yes ❑ No If Yes, please list: _____

Are you taking any medications? ❑ Yes ❑ No If Yes, please list:_____

Do you have any health concerns? ❑ Yes ❑ No If Yes, please explain: _____

Have you ever been hospitalized? ❑ Yes ❑ No If Yes, Age(s) & Please explain: _____

Have you ever had any surgeries? ❑ Yes ❑ No If Yes, Age(s) & Please explain:_____

Have you ever had (or currently have) any of the following? If yes, check all that apply.

❑ ADHD/ADD	❑ Depression	❑ Scoliosis
❑ Alcohol/Drug use	❑ Diabetes	❑ Seizures
❑ Allergies	❑ Headaches/migraines	❑ Shortness of breath
❑ Anemia	❑ Heart problems/rheumatic fever	❑ Skin problems/acne
❑ Anxiety	❑ Hepatitis	❑ Sports injuries or broken bones
❑ Asthma	❑ Meningitis	❑ Strep/tonsillitis
❑ Bladder/kidney infections	❑ Mononucleosis	❑ Thyroid problems
❑ Chicken pox	❑ Pneumonia	❑ Ulcer or digestive problems
❑ Concussion	❑ Scarlet fever	❑ Other _____

Family Medical History:

Please check if any of your family members (mother, father, siblings, grandparents, aunts, uncles) have ever had (or currently have) any of the following? If yes, relationship to patient (parent, grandparent, sibling, etc.)

❑ Alcoholism _____	❑ High blood pressure _____	❑ Suicide _____
❑ Allergies _____	❑ High cholesterol _____	❑ Thyroid disease _____
❑ Arthritis _____	❑ Kidney disease _____	❑ Tuberculosis _____
❑ Asthma _____	❑ Lung disease _____	❑ Ulcer or digestive problems
❑ Birth defects_____	❑ Mental illness/depression _____	_____
❑ Cancer _____	❑ Obesity _____	❑ Other_____
❑ Diabetes _____	❑ Seizures _____	
❑ Drug use/addiction_____	❑ Smoking _____	
❑ Heart disease _____	❑ Sudden death _____	