NICE Child & Adolescent Mental Health Center
300 Westwood Drive, Ishpeming MI 49849
Phone: (906) 485-1023
www.mqthealth.org

Parent/Guardian Consent Form

Please read and complete FRONT and BACK of this form. This form is needed for each student to be seen in the Center. Please use Ink

Student name (Last Name, First Name, Middle Initial, Preferred Name):	Date of Birth:	Age:	Gender: ☐Male ☐Female ☐Other	Grade:

Address:	City:	Zip:	Student telephone:	Today's Date:

Name of student's employer	Your estimate of student's annual income

Race/Ethnicity (Optional):
☐Black or African American ☐White ☐Hispanic/Latino ☐American Indian/Alaskan Native ☐Arab ☐Asian ☐Native Hawaiian/Pacific Islander

Parent/Guardian (Last Name, First Name, Middle Initial):	Relationship to Student:
Address (if different than child):	Parent E-Mail Address:

Home Phone:	Cell Phone:	Work Phone:
Name of Emergency Contact:	Relationship to Student:	Telephone #:

Name of Student's Physician/Clinic:	Date of last annual exam (Well Child):
Name of Student's Dentist/Clinic:	Date of last exam:

Insurance:
☐Medicaid ☐Blue Cross/Blue Shield ☐MI Child ☐Tricare ☐Other:_____ ☐No insurance

Policy Holder Name (Last Name, First Name, Middle Initial):	Date of Birth:	Relationship to Student:

Address:	City:	State:	Zip:

Policy ID #:	Group #:

I have been fully informed and I give my consent to the following:

- The NICE Community School District may release information to the Marquette County Health Department (MCHD) for the purpose of receiving treatment and the MCHD may release information to the NICE Community School District for the purpose of educational case management.
- The above named student may receive all services listed on the back of this form at the MCHD Mental Health Center. If I am requesting any changes to this consent, I will submit the changes in writing to the Center.
- Both the MCHD and my child's primary care physician may exchange health care information for the purpose of continuity and coordination of care according to State and Federal laws.
- Completion of a risk assessment by the above named student.
- This consent form will remain active and on file at the MCHD Mental Health Center while my student is enrolled in the NICE Community School District unless rescinded by me in writing.
- The MCHD may bill my health insurance carrier for services provided to my child. The parent/guardian may be responsible for copay and deductible amounts.
- The MCHD does not discriminate on the basis of race, color, national origin, age, disability, religion, gender, gender identity or sexual orientation.

I understand that the MCHD is in compliance with all HIPAA laws and regulations. The Privacy Notice is available at the center or online at: www.mqthealth.org. I understand that I have the right to refuse to sign this consent form; however, my child will not be able to be seen at the center.

Signature of Parent/Guardian: _____

Printed name: _____ Date: _____

STUDENT MEDICAL HISTORY (OPTIONAL):

Taking daily medication(s) □ Yes □ No ***Name of medication(s) and Dosage *Condition for medication(s)	Food Allergies/Sensitivities: (list below) □ Yes □ No
Medication Allergies: (list below)	Surgeries (type:_____) □ Yes □ No Overnight Hospitalizations (why) □ Yes □ No

FAMILY MEDICAL HISTORY (OPTIONAL):

Please check below if any of your child's relatives (mother, father, sister, brother, aunt, uncle, grandparents) have had any of the Following illnesses and note who had them.

□ Major Depression	
□ Bipolar Disorder	
□ Anxiety Disorder	

Services provided at the NICE Community Schools Mental Health Center:

Parental consent is required for the following services provided to students/patients under the age of 18:	***Current Michigan Law allows for confidential services to mature minors in these areas:***
• Mental health assessment, counseling, and referrals • Individual, group, family, and community education • Referrals for specialty services • Telehealth services	• Physical/sexual abuse counseling and referrals • Crisis intervention • Substance abuse education, counseling, and referrals

Check the appropriate box:

☐ I would like to schedule an appointment for my child. Please call me to schedule an appointment at this phone number _____.

☐ Please keep this consent form for future use, if needed.

Please complete and return to your school office at your earliest convenience.
You may also mail your form to:

Jamie Dieterle, LMSW-C, CAADC, CAGCS
Westwood High School
300 Westwood Drive
Ishpeming MI 49849