University of Michigan Health-Sparrow

Welcome Letter – School-Based Health Center

Dear Student/Parent or Guardian:

The University of Michigan Health – Sparrow has partnered with some community schools within the Eaton and Ingham county area to offer School-Based Health Centers. The goal of the School-Based Health Centers is to improve the health and well-being of students and families.

What is a School-Based Health Center?

- The School-Based Health Centers are staffed by Advanced Practice Providers, Medical Assistants and/or Clinical Social Workers.
- Offered services include a range of physical, mental, and behavioral health services to children and young adults.
- The Health Centers are not intended to replace an existing Primary Care Provider (PCP) but are designed to complement PCPs. For patients who do not have a PCP, the Health Center provider can serve as their PCP.

What can I do to register?

- Please complete the enclosed forms and return them to your school office or Health Center via mail or in person. The enclosed forms include:
  - **General Consent for Healthcare Services**
  - **Health History Questionnaire**
  - **We also need a copy of the patient's health insurance card (front and back)**

How is private health information shared?

Please visit the University of Michigan Health – Sparrow Notice of Privacy Practices website at https://www.uofmhealthsparrow.org/privacy-policy/notice-privacy-practices or ask the Health Center for a copy of the privacy policy. This notice describes how medical information may be shared. Please review it carefully.

Thank you,
University of Michigan Health – Sparrow School-Based Health Center Team

East Lansing High School
509 Burcham Dr.
Door 59
East Lansing, MI 48823
Phone: (517) 827-6290
Fax: (517) 827-6293

Grand Ledge High School
820 Spring St
Door 20
Grand Ledge, MI, 48837
Phone: (517) 925-5590
Fax: (517) 925-5591

University of Michigan Health-Sparrow
Frequently Asked Questions

1. **Who can receive care at the Health Centers?**
   - Youth and young adults ages 5 – 21
   - Infants and children of young adults
   - Young adults up to age 26 who are enrolled in the special education program
   - Appointments and walk-ins welcome. See school's website for hours and locations.

2. **What Services do the Health Centers provide?**

The following services may be provided at the Health Center:

- Preventative care
- Medication administration
- Treatment of acute and chronic injuries and minor illnesses
- Physical exams for school, sports, and camps
- Well-child visits
- Referral for specialty care
- Health education
- Risk assessments
- Immunizations
- Medicaid outreach and enrollment
- Behavioral health services
- Group therapy
- Crisis intervention
- *Physical/Sexual Abuse Counseling and Referrals
- *Substance Abuse Education, Counseling, and Referrals
- *Sexually Transmitted Infection and HIV Testing, Treatment, and Counseling
- *Pregnancy Prevention Counseling, Testing, and Referrals
- **Mental Health and Psycho-Social Assessment, Counseling, and Referrals (limit of 12 visits in 4 months)

Services NOT provided: Distribution or prescription of birth control pills and/or devices, such as condoms, abortion counseling, referrals, or services

* Michigan Law allows minors to receive confidential services in these areas without parental consent.

** Michigan Law allows minors 14 years and older to receive confidential services in these areas without parental consent.

The confidential services will remain confidential unless:

- The healthcare provider believes there is a medical reason to inform a parent/guardian. The provider will first talk with the minor before telling a parent/guardian;
- The healthcare provider believes the minor may harm themselves. The provider will first tell the minor that they are going to tell a parent/guardian; or
- The minor threatens to hurt someone else. If the healthcare provider believes the minor will hurt the other person, then the healthcare provider must tell the other person and the police. The healthcare provider will talk to the minor about the threats and will tell a parent/guardian.

Healthcare providers are required to report suspected child abuse or neglect to Child Protective Services.

3. **Is insurance required to receive care?**
   The health center will bill your insurance. However, the health center will treat uninsured patients, regardless of ability to pay.

4. **How will parents be informed of non-confidential treatment provided at the health center?**
   The After Visit Summary can be found within the patient's MySparrow portal. If the patient does not have a MySparrow portal, then the After Visit Summary will be communicated via phone. Visits that fall under the minor consent agreement for confidential services will be handled in accordance with Michigan law. To learn more about MySparrow and to create a MySparrow portal, visit https://www.uofmhealthsparrow.org/patient-resources/mysparrow.

5. **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 University of Michigan Health – Sparrow School-Based Health Center at any time by mailing or hand delivering a letter signed by parent or guardian for minor or the patient for patients 18 and over the School-Based Health Center or:

University of Michigan Health – Sparrow
Health Information Management and Medical Record Department
1215 E. Michigan Ave., Lower Level
Lansing, MI 48912

University of Michigan Health-Sparrow **School-Based Health Center** **General Consent for Healthcare Services and Important Patient Information - CHILD**	MRN (office use only): NAME: BIRTHDATE:

Notice of Privacy Practices (NPP) Acknowledgement

I hereby acknowledge I have been offered or received the University of Michigan Health – Sparrow 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 University of Michigan Health – Sparrow including medical, psychological, nursing and/or other health care. Services may include:

- Physical exams, health education and immunizations
- Basic lab tests e.g. urinalysis, rapid strep, venipuncture
- Diagnosis and management of acute chronic illnesses
- HIV / STI services (e.g. screening, testing, counseling, etc.)
- Behavioral health screening and management
- Individual and group psychotherapy
- Medication administration
- Minor-consented services
- Telemedicine services
- Other treatment necessary for my care

I agree that University of Michigan Health – Sparrow (UMH-Sparrow) can share my child's health information as needed for care or billing and that various departments may contact me. To facilitate my child's care and medical needs, UMH-Sparrow 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 a 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 it is impossible to avoid certain risks in the practice of medicine.

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 UMH-Sparrow does not allow it. I assign all rights and benefits to UMH-Sparrow in order to help the process of paying UMH-Sparrow for health care services my child received. I agree to help UMH-Sparrow follow up on these claims.

I further understand:

- my child may visit the health center without a parent or guardian present and without phone call notification prior to the visit;
- I, as the original signer of this consent, can withdraw this consent at any time by submitting a request in writing to the School-Based Health Center or University of Michigan Health – Sparrow Health Information Management and Medical Record Department, 1215 E. Michigan Ave., Lower Level, Lansing, MI 48912 via mail or in person;
- my child may have the opportunity to participate in health and wellness related educational programs and can give feedback on services and programs through surveys or focus groups;
- my child may be administered a behavioral risk assessment during their visit. The results of the assessment will be included in the After Visit Summary, as allowed by Michigan law;
- testing for bloodborne diseases, including HIV/AIDS, may be performed on my child without separate written consent if a healthcare professional is exposed to a patient's blood or body fluids;
- no person will be denied services regardless of ability to pay; and

- patient's privacy and health information will be handled in a confidential manner consistent with the University of Michigan Health – Sparrow's Notice of Privacy Practices, which can be found at https://www.uofmhealthsparrow.org/privacy-policy/notice-privacy-practices or at the Health Center, and as required by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

☐ I refuse to consent to immunizations for my child

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

_____ _____/_____/_____
Printed Name of Minor Birthdate (mm/dd/yyyy)

University of Michigan Health-Sparrow **School-Based Health Center** **Health History Questionnaire**	MRN: NAME: BIRTHDATE:	FOR OFFICE USE ONLY

To register for the School-Based Health Center, please fill out this health history questionnaire.

_____ _____

Name of individual completing this form Date

PERSONAL INFORMATION

Patient's Name: _____ **Nickname (if applies):** _____

School: _____ **Grade:** _____

Date of Birth: _____ **SS#:** _____ **Cell #:** _____

Email: _____ **Legal Sex:** ___ Male ___ Female ___ Unknown ___ X

Gender Identity: ___Choose not to disclose ___ Male ___ Female ___ Transgender Male ___ Transgender Female ___ Other ___ Non-Binary ___ Unknown

Sex Assigned at Birth: ____ Female ____ Male ____ Uncertain ____Unknown _____ Not recorded on birth certificate

Sexual Orientation: ___ Unknown ___ Straight ___ Bisexual ___ Lesbian/Gay ___ Self-Identify

What language do you speak at home?_____ **Needs Interpreter?** _____Yes _____No

Race: Asian ____ American Indian and Alaska Native ____ Black or African American ____ Native Hawaiian or Other Pacific Islander ____ White ____ Other_____

Ethnicity: ____ Hispanic or Latino ____ Not Hispanic or Latino

Religion: _____

Parent/Guardian's Name: _____ **Date of Birth:** _____

Email: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Preferred method of contact during health center hours:

☐ Email ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Parent/Guardian's Name (if child is under 18): _____

Date of Birth: _____

Email: _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

Preferred method of contact during health center hours:

☐ Email ☐ Home Phone ☐ Work Phone ☐ Cell Phone

If a parent/guardian needs to be contacted during health center hours, which parent/guardian should be contacted first? _____

Patient's Address: _____City: _____State: _____ Zip: _____

With whom does the patient reside? _____

Does your child have a Primary Care Provider (PCP)? _____Yes _____No

Name of PCP: _____

Preferred Pharmacy and Location: _____

INSURANCE INFORMATION

Please provide a copy of your insurance card(s)

Name of Primary Insurance			
Subscriber's Name		Subscriber's Date of Birth	
Group #		Policy #	
Name of Secondary Insurance (if applicable)			
Subscriber's Name		Subscriber's Date of Birth	
Group #		Policy#	

University of Michigan – Sparrow offers financial assistance for uninsured and under-insured patients. Financial Counselors are available to assist patients apply for programs to help meet the cost of care, including Medicaid, Marketplace, self-pay discounts, and the Sparrow Financial Assistance program. If you need help paying for the cost of care, please contact the Sparrow Financial Counseling Department 517-364-6060 to discuss options.

EMERGENCY CONTACT INFORMATION

Emergency Contact Name: _____

Phone #: _____ Relationship to Patient: _____

ALLERGIES

Please list all allergies and types of reactions.

Allergy	Type of Reaction

MEDICATION

Please list all medications (including over-the-counter medications, vitamins, and supplements).

Medication Name	Medication Strength	How often	Who Prescribed the Medication

MEDICAL HISTORY

Condition	Yes	No
Allergies		
Anemia		
Anxiety		
Arthritis		
Asthma		
Blood Transfusion		
Cancer		
Clotting Disorder		
Depression		
Diabetes		
GERD (Reflux)		
Heart Disease		
Heart Murmur		
HIV/AIDS		
High Blood Pressure		
Kidney Disease		
Meningitis		
Nerve/Muscle Disease		
Seizures		
Sickle Cell Anemia		
Thyroid Disease		
Tuberculosis		
Ulcers		

List other Medical History not listed above or important details:

SURGICAL HISTORY

Surgery	Yes	No
Appendectomy (appendix removal)		
Cosmetic Surgery		
Heart Surgery		
Brain Surgery		
Eye Surgery		
Small Intestine Surgery		
Cholecystectomy (gallbladder removal)		
Fracture Surgery		
Spine/Back Surgery		
Colon Surgery		
Hernia Repair		
Tonsils or Adenoids		
Tympanostomy (ear) tubes		

List other Surgical History not listed above or important details:

FAMILY HISTORY

Some health problems are passed from one generation to the next. Please identify any health problems. If Family History is unknown, please check the box below.

☐ Unknown Family History

Relationship	Status (Living/Deceased)	Adopted (Yes/No)	Age	Health Problems	Cause of Death
Mother					
Father					
Sister					
Brother					
Maternal Grandmother					
Maternal Grandfather					
Paternal Grandmother					
Paternal Grandfather					
Other					

VACCINATION RECORDS

Please provide a copy of your vaccination records.