# Parent/Caregiver
**Consent Form**

A Child and Adolescent Health Center
In Partnership with Family Health Care

Please review this information, initial next to the paragraph headers and sign below. You are welcome to contact us at any time with questions/comments you may have.

I consent to the following for (child's name) _____ (Date of Birth) ____-____-____.

_____ **Medical, Dental, and Behavioral Health Services:** I authorize my child to receive medical, dental, and behavioral health services as offered and available by the Child and Adolescent Health Center. I further authorize any physician, dentist, behavioral health provider, or physician/dentist designated health professional employed by or working for Family Health Care, Inc., remaining within their scope of practice, to provide such medical, dental, and mental health tests, counseling, procedures, treatments, prescriptions, and medications as are reasonable, necessary or advisable for the medical, dental, and emotional evaluation and management of my child's health care.

As you may be aware, Michigan Law Health Code, Act 368 of 1978 requires that minors of certain ages be allowed to receive reproductive health, HIV, STD/STI, substance abuse, and mental health information and services without parental consent at any medical facility in the State of Michigan. For our part we, your Health Center and Public School staff, promote abstinence and encourage open communication between parents, students, and staff at all times.

_____ **Exchange of Information:** I authorize the exchange of information between school officials and clinic staff enabling my child to receive the best available services. Information might include medical, educational, and/or mental health information only as necessary to ensure your child's safety and well-being on a "need to know" basis. We understand and value you and your child's privacy.

As part of a comprehensive, best practice visit, students 10 years and older will take the Rapid Assessment for Adolescent Prevention Services (RAAPS) by their 3rd visit. This is a confidential; 21-question survey that covers dietary, safety, bullying, substance use, sexual, and other risk behaviors. This allows for the provider to quickly assess risk areas the patient needs counseling on during their visit. For more information about the RAAPS, go to www.raaps.org.

**NO family planning, birth control pills or contraception devices will be dispensed or prescribed; NO abortion counseling, referrals or services are provided.**

**Signature:** By signing this consent form I certify that I am the parent/legal guardian of the student named above.

(Parent or Legal Guardian):_____ Date: _____

*I may cancel this authorization by written request at any time.*

**(Office Use Only)**
Health Center consent authorization verification: _____ Date: _____
(Health Center Staff Signature)

Verified By: ____ Phone with parent/legal guardian
____ In person with parent/legal guardian
____ By mail certified to parent/legal guardian (SASE returned)