

## Welcome Letter

The Grand Ledge Public Schools Health Center is a school-based health center providing a range of physical, mental, and behavioral health services to children and young adults in Eaton County. The Grand Ledge Public Schools Health Center is not designed to replace an existing Primary Care Provider (PCP); the health center aims to complement PCPs and other medical providers by increasing access to healthcare and improving the overall well-being of youth in the Eaton County community. However, for patients who do not have a PCP, the provider at the health center can serve as their PCP. The health center is open year-round and is located within Grand Ledge High School.

**Grand Ledge Public Schools Health Center**

820 Spring St  
Suite 100  
Grand Ledge, MI, 48837

**Phone #:** 517-925-5590

**Fax #:** 517-925-5591

To register, complete the following forms and return them to the Grand Ledge Public Schools Health Center via mail or in person:

- Consent for Healthcare Services
- Health History Questionnaire
- Copy of Insurance Cards (front and back)

### FAQ

**1. Who is providing the physical, mental, and behavioral health services?**

University of Michigan Health-Sparrow is staffing the health center with an Advanced Practice Provider and a Medical Assistant who will be responsible for all physical health services. Eaton Regional Education Service Agency (RESA) is staffing the health center with a clinical social worker responsible for all behavioral and mental health services.

**2. Who can receive care at the health center?**

- 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

**3. Is insurance required in order to receive care?**

The health center will accept insured and 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 [www.sparrow.org/patient-resources/mysparrow](http://www.sparrow.org/patient-resources/mysparrow).

**5. Are appointments required?**

No. The health center will accept walk-ins in addition to appointments.

**6. What are the health center hours?**

Monday, Tuesday, Thursday 8:00 am – 4:30 pm  
Wednesday 8:00 am – 6:30 pm  
Friday 8:00 am – 2:30 pm

Visit the Grand Ledge Public Schools Health Center website for more information.

[www.glcomets.net/HealthCenter](http://www.glcomets.net/HealthCenter)



Consent for Healthcare Services

Patients 18 or older may complete this consent form on their own without a parent/guardian signature.

A parent/guardian must complete and sign this consent form for patients under the age of 18.

Patient Name	
Date of Birth	

The following services may be provided at the Grand Ledge Public Schools 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 support services
- \*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)

\* 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.
- 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.

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

I give my consent for \_\_\_\_\_ to receive medical and behavioral health treatment at the Grand Ledge Public Schools Health Center.

**If you want to DENY consent for immunizations, check this box.**

**Directions: Check the box after you read and understand each statement.**

- I understand that patients may visit the health center without a parent/guardian present and without a phone call notification prior to the visit.
- I understand that I can withdraw consent at any time by the original signer of consent by submitting a request in writing to the Grand Ledge Public Schools Health Center via mail or in person.
- I authorize the Grand Ledge Public Schools Health Center to release information regarding treatment to the following: University of Michigan Health-Sparrow and Eaton RESA health center staff and third-party payers when needed for payment of services.
- I authorize both the Grand Ledge Public Schools Health Center and PCPs to exchange healthcare information for the purpose of continuity and coordination of care.
- I understand that patients 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.
- I understand that patients 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.
- I understand that testing for bloodborne diseases, including HIV/AIDS, may be performed without separate written consent if a healthcare professional is exposed to a patient's blood or body fluids.
- I understand that I may be responsible for any insurance co-pays and immunization administration fees.
- I understand that services are provided with charges based on the patient's income, and I understand that no one will be denied services regardless of ability to pay.
- I understand that the patient's privacy and health information will be handled in a confidential manner consistent with the Notice of Privacy Practices, which can be found in the health center, and as required by the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA).

SIGNATURE: \_\_\_\_\_

PRINTED NAME: \_\_\_\_\_

DATE: \_\_\_\_\_



### Health History Questionnaire

To register for the Grand Ledge Public Schools 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:** \_\_\_ Male \_\_\_ Female \_\_\_ 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:** \_\_\_ White \_\_\_ Black or African American \_\_\_ Asian \_\_\_ American Indian and Alaska Native  
\_\_\_ Native Hawaiian or Other Pacific Islander \_\_\_ 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:** \_\_\_\_\_ **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)

<b>Name of Primary Insurance</b>			
Subscriber's Name		Subscriber's Date of Birth	
Group #		Policy #	
<b>Name of Secondary Insurance (if applicable)</b>			
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.