Alcona health center
"Your family health center"

Gaylord Youth Support Program
Parent/Guardian Consent for Services

Received_____ _____
Initials Date

Child/Adolescent Name	Birth Date	Age	Gender	Grade	School/Teacher

Street Address	Mailing Address (PO Box)	City	Zip Code	Child Social Security #

Race (Optional) ❒ **White** ❒ **Black** ❒**Asian** ❒**American Indian** ❒ **More Than One** ❒ **Other**

Ethnicity (Optional) ❒ **Non-Arabic/Non-Hispanic** ❒**Hispanic** ❒**Arabic**

Mother/Parent Name	Mother/Parent Birth Date	Mother/Parent Social Security #	Phone Number

Father/Parent Name	Father/Parent Birth Date	Father/Parent Social Security #	Phone Number

Preferred Telephone Number	May We Leave a Message? Yes No	Best Time of Day to Be Contacted?

Guardian Last Name (if different than mother/father)	Guardian First Name	Guardian Telephone Number	Relationship To Student

Name of Emergency Contact (other than parent/guardian)	Relationship	Telephone Number

Name of Student's Physician or Clinic	Physician or Clinic Telephone Number	Name of Student's Dentist

HEALTH INSURANCE (Please complete all information)

❒ **None (uninsured) Please contact me about MI Child/Healthy Kids health insurance for my child.** ❒ **Yes** ❒ **No**

❒ **Medicaid/Medicaid HMO** **Child's Card Number** _____

❒ **Blue Cross/Blue Shield**
❒ **Blue Care Network**
❒ **Priority Health**
❒ **TriCare**
❒ **Other:**_____

Name of Policy Holder _____
Insurance Policy Number _____
Insurance Group Number _____
Birth Date of Policy Holder _____
Relationship of Policy Holder to child?
_____
Does your insurance pay for immunizations? ❒ **Yes** ❒ **No**

1. Would you like information from our staff regarding:	
Options for health insurance?	❒Yes ❒No
Finding a health care provider (doctor or nurse practitioner)?	❒Yes ❒No
Finding a dentist?	❒Yes ❒No
2. Are you concerned about your income meeting the basic needs of your family?	❒Yes ❒No

Please circle your concerns: Food Clothing Housing Paying for bills for heat and water Transportation to medical or school appointments

If you answered YES to any of the above, a member of our staff will contact you

BEHAVIORAL HEALTH TREATMENT CONSENT FORM

Alcona Health Center (AHC) is offering behavioral health services (BHS) at the Gaylord Intermediate School, South Maple and North Ohio Elementary Schools. This is a service to students enrolled in at the Gaylord Intermediate School, South Maple or North Ohio Elementary Schools. These services will be provided by ***Stephanie Vanniman, LMSW, Licensed Master's Social Worker****, employed by AHC as a Behavioral Health Therapist. In order for those services to begin, a parent or legal guardian must give written, informed consent, as outlined below.*

As the parent or legal guardian of _____ *(Name of child)*

Parent/Guardian Signature needed here.

Consent for Services

1. I understand that BHS will include a behavioral health assessment of my child, during which I will be asked to provide information about my child's emotions needs, and behavior at home and school. I will be invited to be actively involved in the treatment planning for my child. Acceptance of counseling services for my child is on a voluntary basis, and I may terminate these services at any time.
2. I understand that **Stephanie Vanniman**, ***LMSW***, maintains professional liability coverage, and follows federal and state laws protecting client's rights to confidentiality of personal information. I understand these laws allow the exchange of Protected Health Information with other medical personnel involved in the treatment of my child. I have the right to be informed of these exchanges of information and may request more information about HIPPA from my provider.
3. I understand it is not necessary to renew my consent yearly. I further authorize the Gaylord Youth Support Program to release information regarding treatment to the following: Gaylord Youth Support Program staff and its subcontractors, and other health care providers when needed to coordinate care; school staff when needed to coordinate services at school; and third-party payers when needed for payment of services. I understand I may withdraw my consent for services at any time upon written notice.
4. By signing this agreement I am aware it is my responsibility to get consent for treatment from any other adult who has legal right to be informed of treatment.
5. I understand that counseling is a fee for service agreement and that my insurance company will be billed for services, and that I will be responsible for any additional fees not covered by the insurance provider.
6. I understand that federal and state regulations protect the confidentiality of my child's records maintained by this program, except when the following conditions exist:
    a. There is suspected evidence of child abuse, neglect, or danger to my child; or,
    b. My child makes a serious threat to harm themselves (suicide) or others (homicide); or,
    c. A medical emergency requires disclosure to medical personnel; or,
    d. My written permission is given to release this information, which may be authorized to specific agencies or persons on a separate consent form.

I have read and understand the conditions outlined above, and by signing below allow Stephanie Vanniman, L.M.S.W to offer Behavioral Health services to my child.

_____ _____

Signature of Parent(s) or Legal Guardian Date Signature of Witness Date

Please return completed form to:

<u>South Maple Elementary School</u>
650 E. Fifth St.
Gaylord, MI 49735
Room 34
(231) 348-9900 ext. 5157

<u>North Ohio Elementary School</u>
912 N. Ohio Ave.
Gaylord, MI 49735
Room 34
(231) 348-9900 ext. 5157

<u>Gaylord Intermediate School</u>
240 E. Fourth St.
Gaylord, MI 49735
Room 2A
(231) 348-9900 ext. 5157

The Gaylord Youth Support Program is operated by Alcona Health Center, with major funding from Petoskey Harbor Springs Foundation, Michigan Health Endowment Fund, Michigan Department of Health and Human Services and Michigan Department of Education.

CHILD INTAKE FORM

GENERAL INFORMATION

Welcome to Gaylord Youth Support Program. Thank you for taking the time to fill out this form. The information you provide here is protected and confidential information and will be helpful for the therapist to care for your child. ***If you need help completing this form please bring to the first session.***

Child's Name:_____ Today's Date:_____

What is the main reason(s) you're seeking help for your child? (Include how long he/she's had these symptoms or problems):

_____

_____

What are your hopes regarding your child's therapy?_____

_____

_____

HEALTH & MENTAL HEALTH INFORMATION

Does your child currently have any medical problems? _____

_____

Has your child ever been treated for any of the following? If so please circle and describe:
Head injury or loss of consciousness, frequent ear infections, tubes placed, hearing or vision problems, headaches, meningitis, seizures, asthma, elevated lead levels, slow/fast growth, allergies, cancer, surgeries, anemia, vitamin deficiencies, any other conditions:

_____

_____

Has your child previously seen a therapist or psychiatrist? If so, what year? Who did he/she see and for what reason? About how many meetings did your child have? Was the experience helpful or not? How so?

_____

_____

Has your child ever been hospitalized for medical or mental illness? If so, list when, where, & reason:

_____

_____

Please list your child's current prescription medications with dosage (psychiatric and general health):

_____

_____

Please list any previous psychiatric medications (with dosage and dates): _____

_____

Do you suspect or know your child drinks alcohol or uses recreational drugs? If so, what kind & how often?

_____

Do you or anyone close to your child consider his/her use to be a problem? Yes No

Who is your child's primary care physician? _____

Who is your child's psychiatrist (if applicable)? _____

When was your child's last complete physical exam (mo/year)? _____

How many times a week does your child exercise? _____What type & how many minutes? _____

_____

What types of food does he/she often eat? _____

_____

Sleep schedule: _____Total hours:_____

Electronic/Technology/Screen Use_____

YOUR CHILD'S FAMILY

	BIOLOGICAL MOTHER	**BIOLOGICAL FATHER**
Current age, or If deceased date, age, & cause of death		
Country of Origin		
Occupation		
Religious/Spiritual Affiliation (if any)		
Highest grade completed		
Any history of the following (please circle)	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse	Learning Problems Speech Problems Medical Problems Emotional Problems Alcohol or Substance Abuse
Describe each parent's relationship with the child Give some examples of things that you do together & feelings you have		

Parents are (choose one): Married Separated Divorced Living Together

If separated or divorced, how old was your child when the separation occurred? _____

Child lives with (choose one): Both parents Mother Father Other

Who has legal/physical custody? _____

Please describe the current visitation schedule (if any) and type of communication with child's other parent:

_____

_____

Siblings: Please list your child's brothers and sisters in the order of birth (including adopted or step siblings).

First name	Biological, Adopted or Step	Current Age	School grade?	Male/ Female	Lives with you? (Yes/No)	Any medical, social or academic problems (please list for each)?

FAMILY MENTAL HEALTH HISTORY

In the section below identify if any members of your family and extended family has a history of any of the following. If yes, please indicate the family member's relationship to you in the space provided.

	Please circle	List Family Member(s)
Anxiety (general)	Yes No	
Obsessive Compulsive Behavior	Yes No	
Depression	Yes No	
Suicide Attempts	Yes No	
Bipolar/Manic Depressive	Yes No	
Alcoholism	Yes No	
Substance Abuse	Yes No	
Domestic Violence	Yes No	
Eating Disorders	Yes No	
Obesity	Yes No	
Schizophrenia	Yes No	
Counseling or Psychotherapy	Yes No	
Psychiatric Hospitalizations	Yes No	

YOUR CHILD'S DEVELOPMENTAL HISTORY

Pregnancy and Birth

Where there any complications during pregnancy (high blood pressure, diabetes, hospitalization): If so, please describe:

_____

Medications used during pregnancy? Please list: _____

Smoking? Yes No How much? _____
Alcohol intake? Yes No How much? _____
Drug intake? Yes No How much? _____
Length of pregnancy?_____Weeks Age of mother at birth: _____ Birth weight: _____

Were there any complications during delivery? If so, please describe: _____

_____

Length of stay in the hospital? Mother: _____(days) Child: _____(days)

Developmental Milestones and Early Development

At what age did your child do the following (indicate approximate month or year of age for each):

Turn over _____ Crawl _____ Stand Alone_____ Walk Alone _____

First Words_____ First Phrases_____

Toilet trained? Yes No If yes, days?_____Nights? _____

Has your child wet or soiled himself after being trained? Yes No If yes, until what age?_____

Enjoyed cuddling? Yes No Fussy, Irritable? Yes No More active than other babies? Yes No

If your child has siblings, was development different in any way? Explain:_____

_____

YOUR CHILD'S SCHOOL, HOME, SOCIAL & PERSONAL FUNCTIONING

School/Academics

Your child's current grade? _____ Has he/she ever repeated a grade? Yes No If so, which? _____

Other schools attended (grades/year): _____

What preschool experience did your child have? _____

Where any problems detected in your child's kindergarten screening? Yes No If so, please explain:

_____

Is your child in a regular classroom? Yes No Does your child have: an IEP ? Yes No a 504? Yes No

Has your child ever received tutoring/other services (eg. Char/Em ISD) Yes No

If yes, please explain: _____

What are your child's typical grades? _____

What are your child's strongest and weakest points academically? _____

_____

Are you satisfied with your child's educational program? Yes No Please explain: _____

_____

Home/Family Life

What are 5 things that you enjoy most about your child? _____

_____

What are some activities you engage in as a family? _____

Does your child participate in any religious or faith based group? _____

Does your child listen and obey instructions 75% of the time? Yes No

What are your discipline techniques? _____

_____

What are <u>your</u> strengths personally and as a parent? _____

What are some of <u>your</u> areas of needed growth? _____

What are your <u>child's</u> strengths (things he/she is good at)? _____

What are your child's areas of needed growth? _____

Social and Community Engagement

What are your child's favorite activities or hobbies? _____

In what extracurricular/community activities is he/she involved? _____

How does your child get along with other children? _____

Who are some of your child's closest friends (first name)_____

Does your child prefer to play at your home or others' homes?_____

Your Child's Symptoms or Problems

How much are each of the following areas currently a problem for your child?

	Not at all	Some of time	Most of time	Almost all of time	If 2 or 3 please describe
	0	**1**	**2**	**3**	
Anxiety	0	1	2	3	
Physical/Health Concerns	0	1	2	3	
Sleep Problems	0	1	2	3	
Depression/Sadness	0	1	2	3	
Alcohol or Substance Use	0	1	2	3	
Parent-Child/Family Conflicts	0	1	2	3	
Anger/Irritability	0	1	2	3	
Social/Friend Relationships	0	1	2	3	
Academic Difficulties	0	1	2	3	
Sexual behavior/Sexuality	0	1	2	3	
Spiritual/religious	0	1	2	3	
Legal problems	0	1	2	3	
Food/Eating Concerns	0	1	2	3	
Suspected Abuse (physical, emotional, sexual)	0	1	2	3	
Disruptive/Impulsive Behaviors	0	1	2	3	

Has your child experienced any recent or past stressors? Yes No
(e.g., illness, deaths, operations, accidents, separations, divorce of parents, parent changes job, child's changes school, family moved, family financial problems, remarriage, sexual trauma, other losses)?
If yes, please describe:_____

_____

Please use the back provide any additional information which you would like me to know or which you feel would be helpful to better understand your child.

_____ _____

Printed Name/Signature of person completing form Date Signature of Witness Date