INSIGHT
SCHOOL WELLNESS CLINIC

To Parent(s) and/or Guardian(s):

The School Wellness Program Telemedicine Clinic gives your child an opportunity to be seen by a licensed healthcare provider without having to leave the school. An explanation of services offered by the Telemedicine Clinic is listed below. You do not have to be present for your child to be seen; however, a consent form must be signed by you for any services to be rendered.

Description of Services

- Primary care services via telemedicine with Insight Coldwater Pediatric and Adolescent Center
- Care for acute illness and minor injuries such as strep throat, ear infections, rash, and influenza
- Lab testing/referrals as needed
- Preventative care such as immunizations, health education and counseling
- Insurance enrollment assistance for adolescents that are uninsured or underinsured
- Support and coordination of care for students with chronic conditions
- On-site behavioral health counseling

Your insurance will be billed for services provided in the clinic. If you do not have insurance, services will be provided on a sliding fee scale that is based on the student's income. Please contact us if you have any questions or concerns at the following number: 517-279-5477.

Crisis interventions and emergency care do not require consent. Life-saving interventions MAY be initiated without prior consent. Services **NOT** provided at ProMedica School Telemedicine Clinics include prescribing and dispensing contraception, abortion counseling, and long-term psychotherapy.

Current Michigan Law mandates (requires) confidential services to be available to minors in these areas: pregnancy, sexually transmitted infections (STI), human immunodeficiency virus (HIV) testing and counseling, behavioral health counseling, and substance abuse counseling.

Contact Information

Our staff is here to assist you, and we are available to communicate with the parents of each student. We want to know your concerns and be able to keep you updated on your student's health. State law mandates full confidentiality in certain circumstances. The School Wellness Program Telemedicine Clinic works with, and is not meant to replace your family doctor, and at times may communicate with that provider for the purpose of continuity of care. Feel free to contact us during office hours.

Cardinal Connect
Kelli Hills, BSN
275 N. Fremont St.
Coldwater, MI 49036
517-279-5295

Oriole Connect
Mari-Lynn Marquart, BSN
18 Colfax St.
Quincy, MI 49082
517-279-5297

Viking Connect
Jessica McKinley, BSN
450 E. Grant St.
Bronson, MI 49028
517-279-5296

Legg Telehealth
Tara Coats, BSN
175 Green St.
Coldwater, MI 49036
517-279-5458

Mental Health Provider
Katelyn Hamlin, LMSW
517-279-5275

The School Clinics link via telemedicine to the Insight Coldwater Pediatric and Adolescent Clinic under the direction of Dr. Edelwina Dy

ENROLLMENT & CONSENT FORM

STUDENT INFORMATION

Name: _____ Date of Birth: _____ Graduation Year: _____

Address: _____ City/State/Zip: _____

Student Gender: _____ Email: _____Student Cell: _____

PARENT / GUARDIAN INFORMATION – *Date of Birth Required*

Father: _____ Date of Birth:_____ Phone (H/C)_____ (W)_____

Mother: _____ Date of Birth:_____ Phone (H/C)_____ (W)_____

Guardian: _____ Date of Birth:_____ Phone: (H/C)_____ (W)_____

Alternative Contact: _____ Phone (H/C)_____(W)_____

HEALTH INFORMATION

1. List any allergies your child may have and any medications your child should not take: _____

   _____

2. List any medications your child currently takes and why: _____

   _____

3. Family Physician/Pediatrician: _____ or None Dentist: _____
4. If we need to call in a prescription, which pharmacy would you like us to call? _____
5. **Medical Problems:** Please check all that apply for your child:

❑ Asthma	❑ High Blood Pressure	❑ Headaches	❑ Diabetes	❑ Other: _____
❑ Eating Disorder	❑ Seizures/Epilepsy	❑ Depression	❑ Anemia	_____
❑ Heart Problems	❑ Hay Fever/Allergies	❑ Scoliosis	❑ ADD/ADHD	
❑ Anxiety	❑ Learning Disability	❑ Vision or Hearing Problem		

INSURANCE - *POLICY HOLDER DATE OF BIRTH REQUIRED*

☐ INSURANCE: **Please fill out Information and provide copy of card front & back**

Name of Insurance Company: _____

Address: _____

City/State/Zip Code: _____ Insurance Phone #: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ ****Policy Holder*** Date of Birth: _____

Place of Employment: _____

☐ MEDICAID: Please Check One ❑ Meridian Health ❑ United Healthcare ❑ Other _____

ID# _____Group #_____

☐ NO HEALTH INSURANCE - Request application for MI Child/Medicaid or financial assistance

*Please note some commercial insurance companies do not cover the telemedicine facilitation fee. Contact your insurance company to see if your plan covers this service. This charge is not applied to vaccines or sports physicals. If you have questions, please call 279-5477.

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Consent for School Wellness Program Telemedicine Clinic Services

Student's name: _____

I, the parent/guardian of said student, give consent for my child to receive all services at the Telemedicine Clinic. I understand that this consent form is valid for as long as the student is enrolled in Coldwater, Quincy or Bronson Community Schools or until I provide the clinic staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form, you are giving the telemedicine clinic permission to communicate and share medical information with your child's primary care doctor. Communication regarding your child's medical condition will be on an as-needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to healthcare services due to inability to pay. As in any health clinic, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payors for billing purposes.

Confidentiality between the student, parents and the health clinic is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions.

I am the legal guardian of the above-named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above-named child will be shared between the medical provider and the alternative contact.

_____ _____

Signature of Parent / Legal Guardian Date

_____ _____

Staff Signature Date