



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

The School Wellness Program Clinic allows your child to be seen by a registered nurse (RN), mental health provider or licensed healthcare provider at school without leaving campus. A signed consent form is required for services, but parents do not need to be present for your child to be seen. Students 18 or older and emancipated minors may consent for themselves.

Services may include:

- Telemedicine visits with Insight Pediatric & Adolescent Center
- Care for minor illnesses and injuries (strep throat, ear infections, rashes, flu, etc.)
- Lab testing and referrals
- Preventive care such as immunizations, health education, and counseling
- Insurance enrollment for uninsured or underinsured adolescents
- Support for students with chronic conditions
- On-site mental health counseling and teletherapy

Services are available year-round. Insurance may be billed for telemedicine, vaccines, injections, counseling, and teletherapy. Financial assistance is available for families without insurance or who need help paying. Services are provided regardless of sex, race, religion, sexual orientation, or ability to pay. The clinic connects via telemedicine to Insight Pediatric & Adolescent Clinic under the direction of Dr. Edelwina Dy.

Emergency and life-saving care may be provided without prior consent. The clinic does **not** prescribe or dispense contraception, provide abortion counseling or referrals, or offer long-term psychotherapy.

Michigan law allows confidential services for minors in certain areas, including pregnancy, sexually transmitted infections (STIs), HIV testing and counseling, mental health counseling, and substance abuse counseling.

Our staff are available to communicate with parents and address concerns while keeping you informed about your students' health. Some information must remain confidential as required by state law. The School Wellness Program Clinic works with— but does not replace— your family doctor and may contact them to coordinate care. For questions or concerns, please call the program manager at **517-279-5477**.

Contact Information

Cardinal Connect

275 N. Fremont St., Coldwater, MI 49036
Nurse - Kelli Hills, BSN, RN - 517-279-5295
kelli.hills@insightcoldwater.org
Mental Health Provider – Vacant

Legg Connect

175 Green St., Coldwater, MI 49036
Nurse - Tara Coats, BSN, RN - 517-279-5458
tara.coats@insightcoldwater.org
Mental Health Provider – Vacant

Oriole Connect

18 Colfax St., Quincy, MI 49082
Nurse - Mari-Lynn Marquart, BSN, RN - 517-279-5297
mari-lynn.marquart @insightcoldwater.org
Mental Health Provider - Katelyn Hamlin, LMSW - 517-279-5275
Katelyn.hamlin@insightcoldwater.org

Viking Connect

450 E. Grant St., Bronson, MI 49028
Nurse - Jessica McKinley, BSN, RN - 517-279-5296
jessica.mckinley@insightcoldwater.org
Mental Health Provider - Shannan Lester, LMSW - 517-279-5208
Shannan.lester@insightcoldwater.org

KEEP PAGE 1 FOR YOUR RECORDS, RETURN PAGES 2 & 3 TO THE SCHOOL CLINIC



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

Parent: _____ Date of Birth: _____ Phone _____ (Work) _____
Parent: _____ Date of Birth: _____ Phone _____ (Work) _____
Guardian: _____ Date of Birth: _____ Phone: _____ (Work) _____
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: _____ 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: Name of Insurance Company: _____
Please fill out Address: _____
Information and City/State/Zip Code: _____ Insurance Phone #: _____
provide copy of Policy/ID #: _____ Group #: _____
card front & back 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. Telemedicine fees are not applied to vaccines or sports physicals. If you have questions, please call 517-279-5477.



Consent for School Wellness Program Clinic Services

Patient's Name: _____

I give consent for my child to receive services (both medical and mental health counseling) at the School Wellness Program 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 School Wellness Program Clinic permission to communicate and share medical information with your child's primary care physician. Communication regarding your child's medical condition will be on an as-needed basis with the understanding this information will continue to be treated in a confidential manner. Confidentiality between the child, parents and the health clinic are assured. By law, some information requires the child's signed consent prior to disclosure to anyone, including parent/guardian. The staff will encourage every student to involve their parent/guardian in health care decisions.

I understand counseling visits, teletherapy, telemedicine visits, injections and immunizations will be billed to my insurance. I understand my student will not be denied access to healthcare or mental health services due to inability to pay. Insight Hospital and Medical Center – Coldwater may release information regarding treatment to third party payors for billing purposes.

I am the parent/legal guardian of the above-named child. I understand if guardianship changes a new consent must be signed by the legal guardian. I also understand 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.

I authorize the nurse and or mental health provider to speak with school staff on a need to know basis on my child's behalf.

By signing this form, I agree to all of the above terms and conditions.

Signature: _____

Date: _____

Parent/Guardian/Emancipated Minor/Self (18 years and older)

Relationship to Patient: _____

RETURN PAGES 2 & 3 TO THE SCHOOL CLINIC