Michigan City Area Schools
Opportunity * Excellence * Pride

Michigan City High School
8466 W. Pahs Road - Michigan City, IN 46960
Phone: (219) 873-2082 FAX: (219 873-2211

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Open Door Adolescent Health Center
Registration Information Form

Dear Parent/Guardian:

The Open Door Adolescent Health Center will provide health care services to your child by a General Family Physician, Nurse Practitioner, Social Workers, Therapists, and Mental Health Workers on a referral/self referral basis.

SERVICES OFFERED INCLUDE THE FOLLOWING:

- Physical Examination/Wellness Examinations
- Evaluation and Treatment of Minor Illness/Injury
- Bladder/UT Infection Testing
- Nutritional Counseling
- Anemia Testing
- Pregnancy Testing
- Vision Screening and Referrals
- Testing for Low/High Blood Sugar
- Dental Screenings and Referrals
- Teen Parenting & Adolescent Growth Issues
- Information & Community Referrals
- Developmental Concerns
- Preventative and Health Education
- Diet and Weight Control
- Pre/Post Natal Nutritional Counseling
- Skin Care Consultation
- Alcohol/Drug Abuse Counseling
- Depression Counseling
- Smoking Cessation
- Conflict Resolution/Anger Management
- Teen Pregnancy/Parenting Support Groups
- Child Abuse/Neglect Prevention
- Testing for Communicably Transmitted Diseases & Sexually Transmitted Infections

Your signature on this form is necessary for your child to request any of these services.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

Date: _____

I give permission for my child to receive all the above health and mental health services through the Open Door Adolescent Health Center.

☐ Yes ☐ No

Do you want to be notified of any test results?

☐ Yes ☐ No

This permission form is good for school lift, unless we at the Open Door Adolescent Health Center are informed otherwise.

These services are separate from those already offered by the MCAS School Nurse. All medical and mental health counseling services provided by the Health Center are confidential between the professional staff and the student. Students are encouraged to talk to their parents about their medical condition and personal concerns. In the event of an immediate problem, which could jeopardize the student's life, health, or well being, parents will be notified.

All information will be shared with the Indiana State Board of Health for statistical purposes.

In accordance with Indiana State Law, abstinence from sexual activity will be promoted as the only way to avoid pregnancy and sexually transmitted diseases. No birth control devices will be dispensed or prescribed.

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Student Information

School: _____ **Grade:** _____ **Date:** _____

Student's Last Name: _____ **First:** _____ **Middle:** _____

Address: _____ **City:** _____ **State:** _____

Birth Date: _____ **Age:** _____ **Home Phone:** _____

Social Security #: _____ **Gender:** _____ **Race:** _____

Parent 1 Name: _____

Address (if different from the student's): _____

Home/Cell Phone: _____ **Work Phone:** _____

E-mail: _____

Parent 2 Name: _____

Address (if different from the student's): _____

Home/Cell Phone: _____ **Work Phone:** _____

E-mail: _____

Who is the student's legal guardian?

☐ **Parent 1** ☐ **Parent 2** ☐ **Both** ☐ **Other**

If student does not live with parent(s) and is under 18, please list legal guardian:

Name: _____

Relationship to Student: _____

Address: _____

Home/Cell Phone: _____ **Work Phone:** _____

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Health Insurance Coverage for Student

Is Student covered by Medicaid or Hoosier HealthWise? **If Yes, I.D. Number:**

☐ **Yes** ☐ **No** _____

Is Student covered by private health insurance? **If Yes, Insurance Company:**

☐ **Yes** ☐ **No** _____

I.D. Number: **Policy/Group #:** **Name of Insured Person:** **Relationship to Student:**

_____

If no insurance, have you ever applied for Hoosier HealthWise?
☐ **Yes** ☐ **No**

What is your usual source of medical care?
☐ **No Regular Source** ☐ **Emergency Room** ☐ **Health Linc** ☐ **Physician/Clinic**

Is the student currently on any medication? **If yes, Please list:**

☐ **Yes** ☐ **No** _____

Is the student allergic to any medication? **If yes, Please list:**

☐ **Yes** ☐ **No** _____

Does the student have any allergies? **If yes, Please list:**

☐ **Yes** ☐ **No** _____

Does the student have any chronic disease/long-term health problems that the Center should be aware of? If so, please explain:

_____

_____

Does the student have a personal physician who provides medical care to him/her?
☐ **Yes** ☐ **No**

If Yes, Name of Doctor/Clinic: **Telephone:** **When did the student last see this doctor?**

_____

Does the student have a family dentist?
☐ **Yes** ☐ **No**

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If Yes, Name of Dentist: **Telephone:**

_____

Has the student had a dental checkup and cleaning in the past year?

☐ **Yes** ☐ **No**

Names and ages of ALL additional children in your family: (18 and under)

Name: _____ **Age:** _____ **School Attending:** _____

Name: _____ **Age:** _____ **School Attending:** _____

Name: _____ **Age:** _____ **School Attending:** _____

Name: _____ **Age:** _____ **School Attending:** _____

Name: _____ **Age:** _____ **School Attending:** _____

Release of Information and Mutual Exchange

I hereby give permission for the mutual exchange of information about my child, as needed, between the Open Door Adolescent Health Center, Michigan City Area Schools and the following agencies/organizations listed below to assist in providing medical and mental health services to my family.

Name of Persons/Agencies/Organizations to from which information can be disclosed/obtained:

Please check all for which this release applies

☐ **Dunebrook/Healthy Families**

☐ **Physician**

☐ **Hospital**

☐ **Other**

☐ **LaPorte County Circuit Court**

☐ **LaPorte County Division of Family and Children**

☐ **HealthLinc**

Please specify Caseworker, Juvenile Probation Officer, Hospital, Physician, Healthlinc or Other:

_____

I hereby state that to the best of my knowledge, my answers to the above questions are correct.

Parent/Guardian Name (Please Print): _____

Parent/Guardian Signature: _____

Date: _____

The Open Door Adolescent Health Center may use the above information when applying for Grants from Private Foundations and from the State of Indiana. If you do not wish to supply any of the requested data, you are free to omit it. However, we appreciate your completing this form.