Benzie-Leelanau District Health Department (BLDHD)
School Wellness Program (SWP)
Confidential Services for Minors Consent

(For minors, this form must accompany the SWP Student Health Information and Consent)

Under Michigan law, a person who is 12-17 years old can receive some medical care or advice without parent/guardian consent.

This includes:

- Advice, testing or treatment for substance use, sexually transmitted infections, HIV, pregnancy testing or information and referral for birth control services. *You cannot receive pregnancy termination referral services.*
- Minors 14-17 may receive up to 12 mental health visits or 4 months of mental health visits. *You cannot receive treatment with psychotropic drugs without parental consent.*

Your school, in partnership with Benzie-Leelanau District Health Department (BLDHD), may be able to provide the services above to you. When you sign this form, you are consenting to all the following:

- I understand that I must be able to understand the nature and consequence of my actions.
- I understand that the mental health therapist or nurse may notify my parent/guardian of the confidential services I receive for medical reasons or if there is a concern about harm to myself or others. The mental health therapist or nurse will try to inform me before notifying my parent/guardian.
- If a service is provided virtually through telehealth or other method, I understand it is my responsibility to wear headphones or find a place to be alone to ensure privacy on my end.
- I have received/been made aware of BLDHD Notice of Privacy Practices.
- I request and authorize the health care services that the SWP provider advises. This may include assessment, diagnostic testing, therapeutic care or nursing care as allowed by law.
- I understand that in a medical emergency, the SWP Clinic staff will care for me as believed necessary to preserve my life or health.
- I understand that I have the right to refuse or defer treatment unless there is a risk of harm to myself or others.
- *I understand that I can withdraw this consent in writing by email or with the Withdrawal of Parent/Guardian/Minor Consent Form.*

I have read and understand the above information and sign it freely and voluntarily. If I have any questions, I may ask SWP Clinic personnel before I sign this form.

Printed Name: _____ **Birth date:** _____

Phone Number: _____ **Email:** _____

Patient Signature: _____ **Date/Time:** _____

Witness to Signature: _____ **Date/Time:** _____

NOTICE: I understand that testing for blood borne diseases, including human immunodeficiency virus (HIV), may be performed without a separate written consent if a health professional, volunteer, student, or employee of BLDHD is exposed to the patient's blood or body fluids through skin, mucous membrane, or open wound, under Michigan law.

Services are offered without regard to sex, race, religion, or sexual orientation.

You will not receive a bill for receiving a confidential service.