



BAY COUNTY JUVENILE HOME

To Parent/Guardian or referring agency:

Your youth is a current resident at our facility. Attached are a few policies that are required to be shared with you.

Medical Consent: The BCJH contracts a registered nurse and licensed doctor to review resident medications and to handle minor medical issues. The BCJH is required to provide a physical within 7 days of placement unless there is a copy of a physical provided that had been completed in the last 10 months. The youth can request to see the nurse during medical clinic times. Please complete the medical consent form online so that we may attend to your youth's immediate medical needs. The nurse will contact the legal parent/guardian on file to discuss any changes in health status. If for any reason your youth needs to be transported to urgent care or the hospital you will be contacted as soon as possible.

Prescriptions: The staff understand that transportation to the BCJH may not always be convenient or possible. The BCJH utilizes Healthlink Pharmacy. You may choose to have refills transferred to Healthlink and let them know that the prescriptions need to be delivered to the Bay County Juvenile Home. You will need to provide insurance information and pay any co-pays.

Healthlink Pharmacy
322 Garfield Avenue
Bay City, MI 48708
989-391-9068

Immunizations: Immunization Clinic is the first Thursday of each month. The Bay County Health Department administers the immunizations at **no cost**. The registered nurse refers to the Official State of Michigan Immunization Record for each youth to determine the eligibility for immunizations. Immunizations available are Tdap, Hib, Polio, MMR, Hep B, Vericiella, Hep A, Flu, Pneumococcal Conjugate, Meningococcal Conjugate and HPV. Some of these vaccinations are a series. If the youth refuses the immunization we do not force the youth to receive them. The Health Department requires a consent form to be completed. Please see immunization consent form on the website. The BCJH is required to offer these immunizations for youth who remain in the facility after 29 days. If you have an up to date immunization record please fax or email to the BCJH. Fax # 989-892-4419 or email juvhome@baycountymi.gov. You may also give a copy of the record to the Probation Officer or DHHS caseworker to forward to the facility.

Dental: Dental services are provided to youth by licensed professionals.

Thank you,

Bay County Juvenile Home



BAY COUNTY

Juvenile Home

Phone: (989) 892-4519

520 West Hampton Road, Essexville, MI 48732

Visitation is limited to parents/legal guardians and grandparents listed in the residents file unless rights of the parent/legal guardian/grandparents have been terminated by the Court. Other visitors shall be prohibited unless approved by BCJH Administration in advance.

Phone visitations dates and times:

Wednesdays: 6:00pm to 7:30pm

Sundays: 3:00pm to 4:30pm

1. In person visits are scheduled for 30 minutes once a week with parent/guardian and/or grandparent. There will be a maximum of two visitors per visit.
2. If the parent/guardian has questions or concerns they may direct that to the Supervisor on duty or Team Leader. The parent/guardian may call back during business hours to speak with the Director or put concerns in writing.
3. Youth visitation may be suspended if the youth is a security threat to himself or others. This threat must be documented in the youth's file and communicated to the referring agency and parent/guardian.
4. Youth may refuse to visit with parent/legal guardian or grandparents without negative consequence. Any refusal and stated reason for refusal shall be documented in the youth's file. Staff shall contact the visitor of the youth's stated refusal if the refusal is known in advance.
5. All visitors are subject to a metal detector search upon entry to the facility. Purses, bags cell phones, tobacco products, food, drink or other personal items are prohibited. Visitors may be asked to take items back to their vehicle. Coats may be hung in the hallway. There is a locker in the entrance way to secure items while visiting.
6. Visitors shall have suitable identification upon request. Visitation may be denied without valid identification. All visitors must sign in when entering the facility.
7. Visitors are not to pass items to residents without review and approval from Bay County Juvenile Home (BCJH) staff. Passing of items to youth without the expressed permission of Juvenile Home employees is prohibited and will result in termination of visit. If the visit is terminated the reason for the termination must be documented in the youth's file.

8. All visits are monitored by BCJH staff.
9. Young children shall not be left unattended in the parking lot/vehicle while parents are visiting. Children are not allowed in the facility to visit with youth.
10. The visit may be terminated if deemed necessary by BCJH staff.
11. There is absolutely no smoking or use of tobacco products in the Juvenile Home or on the facility grounds by anyone. This is a State Law punishable by fines. This includes the use of any form of vape pen.
12. Type of visit
 - a. Phone call: Youth may receive phone calls from approved legal guardians/parents and grandparents. Youth may make phone calls as long as they have privileges to approved legal guardians/parents and grandparents.
 - b. In person: Residents may receive visits in the facility by approved legal guardians/parents and grandparents on visiting days, during approved visiting hours.
13. Termination of visit: The visit may be terminated if the visit is a detriment to the resident.
 - a. The youth is crying and visibly upset and continuation of visit appears detrimental to youth. Arguing from parent or resident that is disruptive. Constant clinging and touching of resident/parent. Passing of any unauthorized item to the youth/parent.
 - b. Telephone calls will be terminated if it is found the youth is speaking with an unauthorized person. The youth will then receive a point loss unless it is the youth who notifies staff that he/she has an unauthorized person on the line.
 - c. Resident phone calls shall be terminated if the youth's behavior warrants a fine.

All visits that are terminated either by the visitor, youth or BCJH staff must be documented in the youth's file. The reason for the termination of the visit shall be documented whenever possible.



BAY COUNTY JUVENILE HOME

Acknowledgement of Policy

Dear Parent/Guardian or Referring Agency:

It is required that the Bay County Juvenile Home provide each parent/guardian and/or referring agency with a copy of specific policies listed below. It is requested that you initial and sign below indicating that you have received each policy. All policies are available on the Juvenile Home website under "Policy Packet" or available upon request at the Juvenile Home. Please indicate the policies you have received by initialing next to each received policy below:

___ **Program Statement**

___ **Seclusion Policy**

___ **Grievance Policy**

___ **Mechanical Restraint**

___ **Religion Policy**

___ **Emergency Restraint**

___ **Intervention Standards**

___ **Health Status Assessment**

Your signature verifies that you have received a copy of the policies noted above. You understand that if you have questions or concerns you may speak with a Supervisor or the Director.

For further questions or concerns I may contact:

Supervisors Joe Beauchamp and Art Amador or Director Juli Reynolds

Signature: _____ Date: _____

Print name: _____

Youth's Name: _____

Relationship to youth: _____ **OR**

Representing Court/Agency: _____

Staff shall review the form to ensure it is filled out accurately and then

Attach this form into the Youth's file

Revised 8/8/24



BAY COUNTY JUVENILE HOME

MEDICAL CONSENT AND AUTHORIZATION FORM

Resident Name:	DOB:
I hereby consent and authorize: Bay County Juvenile Home 520 West Hampton Road, Essexville, MI 48732 Phone: 989-892-4519 Fax: 989-892-4419 Email: juvhome@baycountymi.gov	
To provide the following services for my child: Routine, nonsurgical medical care, or emergency medical and surgical treatment including consent for hospital admittance, emergency treatment including surgery, dental care or mental health services. All services shall be provided by qualified medical personnel as deemed necessary to protect the health of my child. This consent and authorization includes the authorization for disclosure of my child's complete health records as may be necessary to provided appropriate medical care and treatment and follow-up care. Initial _____	
It is understood that the Bay County Juvenile Home will make all reasonable efforts to notify me of any injury or emergency medical care or treatment that is necessary while my child is in the care and custody of the Bay County Juvenile Home. I understand I have the right to revoke this authorization at any time prior to disclosure by giving written notice to the Facility Director. Initial _____	
I consent to testing for infectious, contagious and sexually transmitted diseases including, but not limited to hepatitis, hepatitis B, HIV and AIDS in the event my child's bodily fluid comes into contact with any volunteer, employee or other youth of the BCJH. Results of that testing will be made available to the Director of the Bay County Juvenile Home. Initial _____	
Last dental exam for youth:	
Last date youth had a physical:	
Is youth up to date on Immunizations:	
Allergies for youth:	
Medication Allergies:	
Include reaction if ingested or exposed. What precautions are required by medical professional?	

Food intolerance or allergy **If your youth has an intolerance to a food please note that it is a food intolerance versus an allergy.**

Include reaction if ingested or exposed. What precautions are required by medical professional?

Other Allergies:

Include reaction if ingested or exposed. What precautions are required?

Does the youth have prescribed medications for allergic reactions such as an EpiPen or other prescription?

Did you bring this prescription to the facility to be available for the youth in the event of an allergic reaction?

Has this youth ever been diagnosed with Asthma?

Yes or No

Does the youth currently have a prescribed inhaler?

If yes, was the inhaler provided to this facility while the youth is lodged?

Will the youth have trouble breathing participating in physical activity without an inhaler? Indoors/outdoors

Does this youth have prescription glasses? Yes No

Are those glasses available to the youth in while lodged? Yes No

Parent/Guardian Signature: _____ Date: _____

Printed Name: _____

Please provide a copy of insurance card if available:

Attest/Refusal to Consent to Vaccination

Bay County Juvenile Home

The Bay County Juvenile Home as a Child Caring Institution is required to offer immunizations to youth every 30 days. The Bay County Health Department will provide immunizations to the youth at the Bay County Juvenile Home every first Thursday of the month unless scheduled otherwise. BCJH staff shall use this document when a parent or youth refuses any recommended vaccine. Place this completed form in the youth's file and provide to the Health Department Nurse who presents for the immunization clinic.

Youth's Name: _____ Youth's DOB: _____

Parent's/Guardian's Name(s): _____

☐ **I attest that my child is up to date on all immunizations and I do not wish that my child have any further immunizations. (SKIP TO SIGNATURE BELOW)**

The Bay County Juvenile Home and/or The Bay County Health Department have advised me that my child (named above) should receive the following vaccines:

Recommended	Vaccine	Declined	Reason for Refusal
	Diphtheria, tetanus, acellular pertussis (DTaP)		
	Diphtheria, tetanus (DT or Td)		
	<i>Haemophilus influenza</i> type B (Hib)		
	Hepatitis A (Hep A)		
	Hepatitis B (Hep B)		
	Human papillomavirus (HPV)		
	Influenza		
	Measles, mumps, rubella (MMR)		
	Meningococcal (MCV or MPSV)		
	Pneumococcal vaccine (PCV or PPSV)		
	Polio (IPV)		
	Rotavirus (RV)		
	Tetanus, diphtheria, acellular pertussis (Tdap)		
	Varicella (chickenpox) (Var)		
	COVID 19		

I have read the Centers for Disease Control and Prevention's Vaccine Information Statement(s) explaining the vaccine(s) and the disease(s) they prevent (BCJH staff have the information available upon request or contact the Bay County Health Department 989(895-4009 option #2). I understand the following:

- The **purpose** of the recommended vaccination
- The **risks and benefits** of the recommended vaccination
- **Possible consequence(s)** of not allowing my child to receive the recommended vaccination may include contracting the illness the vaccine is intended to prevent and transmitting the disease to others
- The Bay County Health Department, the American Academy of Pediatrics, the American Academy of Family Physicians, the Centers for Disease Control and Prevention, and the Michigan Department of Health and Human Services **strongly recommend** that the vaccine(s) be given.

I may contact The Bay County Health Department Immunization Clinic (989)895-4009 option #2 with any questions

I know that I may change my mind and accept vaccination for my child in the future by contacting the Bay County Juvenile Home or the Bay County Health Department and completing the consent forms.

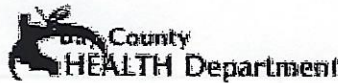
I accept sole responsibility for any consequences as a result of my child not being vaccinated.

I acknowledge that I have read this document in its entirety and fully understand it.

Parent/Guardian Signature

Date

CLIENT CONSENT



fill out both sides please

1200 Washington Avenue
Bay City, Michigan 48708

Client Name: _____ File Number: _____

Any statement not agreed to may be crossed out and initialed by client or client's authorized representative.

CONSENT FOR CARE

I hereby voluntarily consent to authorized BCHD health care professionals including physicians, nurse practitioners, nurses, medical assistants, social workers, and employees of Bay County Health Department (BCHD) to perform services, procedures and/or treatments as prescribed by my physician or in accordance with BCHD specific program/clinic/service protocol.

I further authorize BCHD to obtain specimens of blood, urine, and other body fluids, tissues or products for the purpose of tests or procedures as deemed appropriate for my care. I realize that if tests are taken for sexually transmitted diseases, reporting positive test results to the Michigan Department of Health & Human Services is required by law.

I authorize the use of photographs for the purpose of health care and documentation and transfer to BCHD all rights and interest in such photographs.

I have had the purpose of the program/service explained to me, want to participate, and have reviewed my plan of care (if applicable). I understand the services I am to receive, and understand I can withdraw from participation at any time.

CONSENT TO HIV TESTING

I understand that BCHD may perform an HIV, Hepatitis B and Hepatitis C test upon me without additional written consent in the event a BCHD health professional or designee has a percutaneous, mucous membrane, or open wound exposure to my blood or body fluids. The results of any test(s) will be treated confidentially, but may be disclosed as necessary for care of the health professional or designee at risk for blood borne pathogen infection due to exposure to my blood or body fluids

CONSENT to BILL

I request that payment of the authorized benefits from my health insurance be made on my behalf to BCHD. I certify that the Health insurance information I provided is accurate and correct. BCHD will accept payment from Medicare and Medicaid as full payment for covered services.

In the event the insurance company pays me directly, or if the service is not covered by my health insurance, I or my estate will be fully responsible for reimbursing BCHD.

- ☐ Services to be billed to my insurance
☐ Services to be billed to me

Bill: ☐ Medicare ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Other Insurance
☐ Sliding Fee Scale

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize BCHD to release by mail, phone, fax, or secure encrypted email and/or to obtain all or any portion of my or my child's health record to or from hospitals, health care providers, insurance companies, service agencies, auditors or others involved in my or my child's care that may be pertinent to the delivery, coordination and evaluation of my/my child's care. This includes all information about my or my child's status related to communicable diseases and infections, sexually transmitted infections (STI), Tuberculosis (TB), Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), alcohol and drug abuse treatment information, mental health treatment records, psychological services and social services information including communications made by me to a social worker.

CONSENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OBTAIN PAYMENT

I authorize BCHD and its health care providers to release to any third party payor (Medicaid, Medicare, private health insurance etc.) and their clinical review agencies, or insurance carriers, welfare authority or other person or party responsible for any portion of care that is rendered to me such information from my health records as is required in order for BCHD to receive payment or reimbursement for my treatment, including alcohol, and drug abuse records protected under regulations in 42 Code of Federal Regulations, Part 2 (if any), psychological service records (if any), and social service records (if any). This consent shall be effective only so long as is necessary to obtain payment or retrospective authorization for payment and will expire when final payment has been received. This consent to release medical information is subject to revocation at any time with respect to any drug or alcohol abuse records, except to the extent the information has previously been release in reliance thereon.

This consent can be revoked by the client/client's authorized representative at any time unless the agency has acted in reliance upon its continued effectiveness. Without expressed revocation this consent expires within one year, or (please check) ☐ until no longer enrolled in Children's Special Health Care Services.

☐ I have received a copy of the Bay County Notice of Privacy Practices

I have read this consent form or it has been read to me and have had my questions answered to my satisfaction.

Signature of Client or Authorized Representative

Relationship

Date

Reason for signature of Authorized Representative (instead of Client Signature): _____

Signature of BCHD Representative

Date

IM 07a
Revised 10-18

fill out both sides please

Last		First		M.	Age
Address			City	State MI	Zip
Phone #		Maiden Name		Birth Date / /	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Race <input type="checkbox"/> Caucasian <input type="checkbox"/> African American	<input type="checkbox"/> Hispanic <input type="checkbox"/> Other	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Other		
Insurance Type _____					
Card Holder Name: _____			Card Holder Birth Date: _____		
Enrollee ID _____		Group # _____			
Medicare # _____		Medicaid # _____			

- Are you allergic to eggs, thimerosal (preservative), latex, or have any other allergies? ☐ Yes ☐ No
- Have you ever had an adverse reaction to a flu shot or any other vaccine? ☐ Yes ☐ No
- Have you had Guillain-Barre syndrome within 6 weeks of a flu shot? ☐ Yes ☐ No
- Are you sick today? ☐ Yes ☐ No
- Have you had MMR, Varicella, Nasal Spray Flu or any other vaccines in the past 30 days? ☐ Yes ☐ No
- Have you ever had a seizure or neurological problem? ☐ Yes ☐ No
- Have you taken cortisone, prednisone, steroids, anticancer drugs, or x-ray in last 3 months? ☐ Yes ☐ No
- Have you received a blood transfusion, plasma, or immune globulin in the last year? ☐ Yes ☐ No
- Are you pregnant or is there a chance of becoming pregnant the next 3 months? ☐ Yes ☐ No
- Do you have cancer, leukemia, AIDS, or any other immune system problem? ☐ Yes ☐ No
- Did you receive the vaccine information sheet today? ☐ Yes ☐ No
- Do you have any questions? ☐ Yes ☐ No

MCIR (Michigan Care Improvement Registry)

- ☐ Yes, please register my or my child's immunization history in the MCIR system.
- ☐ No, I do not want my or my child's immunization history registered in the MCIR system.

fill out both sides please

SIGNATURE _____ Legal Guardian Name: _____

For Office Use Only

<input type="checkbox"/> CPOX	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> DTAP	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> FLU	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> HEP A	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> HEP B	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> Hib	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> HPV	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> KINRIX	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> MENACWY	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> MEN B	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> MMR	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> MMRV	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> PCV13	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> PEDIARIX	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> PPSV23	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> POLIO	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> ROTA	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> SHINGRIX	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP
<input type="checkbox"/> TDAP	Lot # _____	Site _____	Manuf. _____	Eligibility \$ or VFC or AVP

Nurse Signature _____