Bayhealth
THE DRIVE IS *here.*

Place Patient Label Here
Name & Date of Birth

SCHOOL-BASED WELLNES CENTER

PARENT/STUDENT CONSENT FOR SERVICES

As a Parent or guardian of a **minor** child (less than 18 years) you can elect whether your child will receive services at the Wellness Center. Students 18 years or older may sign for themselves to receive these services. **(PLEASE PRINT IN INK)**

I, _____, give my consent for _____ to receive
(Name of Parent/Legal Guardian of Student) **(Name of Student)**

health services at the Smyrna H.S. Wellness Center Administered by Bayhealth Medical Center.
(Name of the School)

Wellness Center services include the following, as needed or requested;

PHYSICAL HEALTH

- Assessment, diagnosis and treatment of minor illness and injury
- Physical examinations, including sports/employment/college physicals
- Immunizations in accordance with the Division of Public Health
- Nutrition services and referrals

COUNSELING

- Individual, Group or Family Counseling
- Drug, alcohol and other substance abuse counseling and referrals
- Referrals for long-term counseling or other evaluations

EDUCATION

- Individual and group programs focusing on healthy life choices

The following services are also available to students 12 years of age or older who are enrolled in this school-based Wellness Center. According to Delaware Law (Title 13 §710) a minor child 12 years of age and older can receive these confidential services without parental consent. This law applies to all medical facilities and providers. Information about confidential services can only be shared when your child gives the Wellness Center permission to do so or at the discretion of the health care provider having primary regard for the interests of the minor.

CONFIDENTIAL SERVICES

- Condoms, Hormonal Birth Control (e.g. Oral Contraceptives & Depo)
- Pregnancy testing
- Diagnosis and treatment of sexually transmitted diseases
- HIV Counseling and Testing

THE WELLNESS CENTER DOES **NOT** PROVIDE THE FOLLOWING SERVICES

- Treatment or testing of complex medical or psychiatric conditions
- Ongoing primary treatment of chronic medical conditions
- Complex lab tests
- Hospitalization
- X-Rays

PLEASE COMPLETE OTHER SIDE

Bayhealth

SCHOOL-BASED WELLNESS CENTER

Place Patient Label Here
Name & Date of Birth

PARENT/STUDENT CONSENT FOR SERVICES

It is the Wellness Center's philosophy that parents/guardians should be involved in their child's care. Therefore, the Wellness Center strongly encourages communication and involvement among students, parents and medical providers. School-Based Wellness Centers are funded through state funds and reimbursement from insurance for those students who have insurance.

The Division of Public Health (DPH) retains administrative authority for School-Based Wellness Centers. Designated Wellness Team members are obligated by law to disclose specific patient information to DPH for the purpose of preventing or controlling disease, injury, surveillance, or disability in Delaware and in the US. Information that will be reported includes: sexually transmitted disease, laboratory data, births, deaths, adverse medication reactions, child abuse or neglect, and domestic violence. Other general information may be sent to DPH for statistical tracking, but this information will be de-identified during analysis, which means your child's name will be removed. Information about services may be shared with your health insurance company for purposes of quality improvement.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
BAYHEALTH SCHOOL BASED WELLNESS CENTERS

Effective April 14, 2003, the Wellness Center must comply with the Private Rules as detailed in the Health Insurance Portability and Accountability Act ("HIPAA"). By law we are required to provide you with a copy of the Wellness Center's Notice of Privacy Practices. The Notice describes how the Wellness Center may use and disclose health information about you that we have collected. It also explains how you can get access to this information.

The Wellness Center is committed to taking steps in compliance with applicable law, to protect your privacy and confidentiality. We want you to know that we may use your health information for purposes of your treatment, to obtain payment for services that we provide to you and for purposes of Wellness Center operations. For more information on how we may use and disclose your health information, please read our Notice of Privacy Practices. **You may contact the Wellness Center staff to obtain the most current copy.**

My child and I have read this form carefully and I understand that if I have any questions I may call the Wellness Center Coordinator for more information before I sign this authorization.

By my signature below I agree, as the parent or legal guardian of the student named, or as an adult student that

- He/she may receive services at the School-Based Wellness Center **(the "Wellness Center")**
- This consent will remain in effect as long as my child is enrolled in this school
- This consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the Wellness Center.
- If my child has insurance I will provide this information to the Wellness Center.
- I understand that the Wellness Center will bill my insurance for covered services and it is my responsibility to be aware of the terms and limitations of my insurance coverage.

X _____ _____ _____
Signature of Parent/Legal Guardian Date Time

_____
Print Name of Parent/Legal Guardian

X _____ _____ _____
Signature of Student Date Time

_____
Print Name of Student

Bayhealth
Kent General · Milford Memorial

High School Wellness Center
Registration & Health History

Caesar Rodney Wellness Ctr.	302-698-4280
Dover Wellness Center	302-672-1586
Lake Forest Wellness Center	302-284-9291
Milford Wellness Center	302-424-6120
POLYTECH Wellness Center	302-697-8402
Smyrna Wellness Center	302-653-2399
Woodbridge Wellness Center	302-337-9310

Services **will not** be provided unless all sections of this form are complete. **(PLEASE PRINT CLEARLY IN INK)**

Student Name: _____ **Birthdate** ____/____/____ **Age:** _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Student Phone: (Home) _____ (Cell) _____ **Grade:** _____

Gender: ❒ Male ❒ Female

Ethnicity: ❒Hispanic or Latino ❒Not Hispanic or Latino

Student's Preferred Language: ❒English ❒ Spanish ❒ Other please list_____

Race: Please check ✓all that apply
❒American Indian/Alaska Native
❒Asian
❒Black/African American
❒Native Hawaiian/Pacific Islander
❒White/Caucasian

Name of Student's Medical Provider (Doctor): _____

Address: _____ Phone: _____

❒ **NO PHYSICAN OR MEDICAL PROVIDER**

Name of parent/guardian: _____Relationship to child_____

Parent/guardian Phone: (Home) _____(Cell) _____

INSURANCE INFORMATION IS REQUIRED TO PROCESS STUDENT VISITS AND A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED

Please indicate your medical coverage. _ **NO MEDICAL COVERAGE**

❒ **PRIMARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: ____/____/____ Relationship to child: _____

❒ **Medicaid#** _____

❒ **SECONDARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: ____/____/____ Relationship to child: _____

❒ **Medicaid#** _____

Bayhealth

School-Based Wellness Center-Registration & Health History

Patient Label

A COMPLETE AND ACCURATE HEALTH HISTORY IS NEEDED IN ORDER FOR THE STAFF TO PROVIDE QUALITY HEALTH CARE.

ALLERGY HISTORY

❒ No Allergies

❒ Medication Allergy (please list): _____

Allergy to: ❒ Latex ❒ Peanuts ❒ Eggs ❒ Other (please list) _____

MEDICATIONS: Please list all medications child is currently taking: prescription, over the counter, herbal supplements

Name of medication Dose Reason for use

_____

_____

_____

FAMILY HEALTH HISTORY-Please check ✓ and indicate which blood relative (i.e. parents, grandparents, siblings) have had the following:

☐ Asthma	☐ Anxiety	☐ Depression
☐ Diabetes	☐ Heart Disease/Attack	☐ High Blood Pressure
☐ Kidney Disease	☐ Sickle Cell	☐ Stroke
☐ High Cholesterol	☐ Blood Clots in legs/lungs	☐ Cancer
☐ Obesity	☐ Other:	

STUDENT HEALTH HISTORY

Please check ✓ any of the following conditions that your son/daughter has now or has had in the past.
Indicate with (P)-Past or (C)-Current. Please provide an explanation below for any **CURRENT** problem checked.

☐ ADD/ADHD	☐ Anemia	☐ Anxiety	☐ Asthma
☐ Cancer (type):	☐ Chicken Pox –year:	☐ Cholesterol (high)	☐ Clotting Disorder
☐ Concussion	☐ Depression	☐ Diabetes	☐ Eating Disorder
☐ Headache-Migraine	☐ Hearing Loss	☐ Heart Murmur	☐ High Blood Pressure
☐ Overweight/Obesity	☐ Learning Disability	☐ Rashes/Skin problem	☐ Seizures
☐ Self-injurious Behavior	☐ Physical Limitations	☐ Suicide Attempts	☐ Smokes/Chew Tobacco
☐ Trauma/Violence	☐ Ulcer/Reflux	☐ Vision Problems	☐ Other:

Explanation of CURRENT illness or problems: _____

_____

List all past surgeries:

Type of Surgery	Date

Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness staff to address? ❒ Yes ❒ No

If yes, what are your concerns? _____

_____

Is your teen currently receiving counseling or mental health services: ❒ Yes ❒ No

Name of Counselor/Facility: _____

I have read this form carefully and ***I acknowledge*** that all information requested on the Registration & Health History Form is accurate and complete.

Signature of Parent/Guardian: X _____ Date: _____