



Place Patient Label Here
Name & Date of Birth

SCHOOL-BASED WELLNESS 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 High School Wellness Center Administered by Bayhealth Medical Center.
(Name of 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

***Immunizations** require separate consent before your student receives the immunization.

****Please be aware:** In accordance with Delaware law, any minor age 14 or over may consent to voluntary outpatient mental health services and substance abuse counseling without parental consent.

The following services are also available to students 12 years of age or older who are enrolled in this school-based Wellness Center. In accordance with Delaware law, any minor age 12 or over can receive these confidential services without parental consent. Your child must give the Wellness Center express permission to share information about confidential services with you or the health care provider may share the confidential information at his or her discretion when it is in the minor's interests.

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



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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 student'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 son/daughter and I have read this form carefully and I understand that if I have any questions, I am encouraged to call the Wellness Center Coordinator for more information before I sign this authorization.

I understand that:

- My child may receive services at the School-Based Wellness Center.
- This consent will remain in effect as long as my child is enrolled in this school
- 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.
- This consent can 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.

By my signature below I certify, as the parent or legal guardian of the student named above, I understand the School-Based Wellness Center consent for treatment.

Signature of Parent/Legal Guardian

Printed Name

Date

Time

Signature of Student

Printed Name

Date

Time



Patient Label

School-Based Wellness Center-Registration & Health HistoryServices 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 ☐ Transgender Male ☐ Transgender Female ☐ Decline to AnswerEthnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino
Student's Preferred Language: ☐ English ☐ Spanish ☐ Other: _____Race: Please check ☒ all that apply☐ American Indian/Alaska Native ☐ Native Hawaiian/Pacific Islander ☐ Undetermined
☐ Asian ☐ White/Caucasian ☐ Other: _____
☐ Black/African AmericanIn case of EMERGENCY contact: _____
Name Relationship to student Phone Number

Mother's Name: _____ Phone: (Home) _____ (Cell) _____

Email address: _____ Employer Name: _____

Father's Name: _____ Phone: (Home) _____ (Cell) _____

Email address: _____ Employer Name: _____

Guardian's Name: _____ Phone: (Home) _____ (Cell) _____

Email address: _____ Employer Name: _____

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

Address: _____ Phone: _____

☐ NO PHYSICIAN OR MEDICAL PROVIDER**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# _____

Barcode

Form No. P9909 (5/25)

Wellness Center

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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:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease/Attack	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Sickle Cell	<input type="checkbox"/> Stroke
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Blood Clots in legs/lungs	<input type="checkbox"/> Cancer
<input type="checkbox"/> Obesity	<input type="checkbox"/> 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.

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

Explanation of CURRENT illness or problems: _____

List all past surgeries:

Type of Surgery	Date

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

If yes, what are your concerns? _____

Is your student 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: _____

Date: _____

Barcode



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