SCHOOL-BASED WELLNESS CENTER
PARENT/STUDENT CONSENT FOR TREATMENT

I, ______________________________________________, give my consent for ______________________________ ___ (Parent/Legal Guardian of Student) (Name of Student) to receive health services at the Milford High School Wellness Center administered by: Bayhealth Medical Center Telephone Number: (302) 424-6120

Please circle either Yes or No if you want your child to receive the following services

<table>
<thead>
<tr>
<th>MENU OF SERVICES</th>
<th>CONSENT GIVEN</th>
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<tbody>
<tr>
<td>PHYSICAL HEALTH</td>
<td>(CIRCLE ONE)</td>
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<tr>
<td>• Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury (May include a urinalysis, throat culture, limited blood test, dispensing non-prescription medication and/or providing prescription medication)</td>
<td>YES NO</td>
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<tr>
<td>• Physical examinations, including sports/employment physical</td>
<td>YES NO</td>
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<td>• Immunizations in accordance with the Division of Public Health</td>
<td>YES NO</td>
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<tr>
<td>• Diagnosis and treatment of sexually transmitted diseases</td>
<td>YES NO</td>
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<td>• Coordinating services with student’s Primary Health Care Provider /Other Provider</td>
<td>YES NO</td>
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<td>• Referral of a student who does not have a primary care provider to a physician</td>
<td>YES NO</td>
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<tr>
<td>• Drug, alcohol and other substance abuse counseling and referral</td>
<td>YES NO</td>
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<td>• HIV testing and counseling</td>
<td>YES NO</td>
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<td>• Nutrition counseling</td>
<td>YES NO</td>
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<tr>
<td>• Pregnancy screening</td>
<td>YES NO</td>
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| MENTAL HEALTH                                          | YES NO |
| • Individual counseling | YES NO |
| • Group counseling | YES NO |
| • Family Counseling | YES NO |
| • Referrals for long-term counseling or other evaluations | YES NO |

| EDUCATION                                              | YES NO |
| • Individual and group programs focusing on healthy life choices | YES NO |

| REPRODUCTIVE HEALTH                                    | YES NO |
| • Condoms                                              | YES NO |
| • Oral Contraceptives                                  | YES NO |

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
By my signature below I certify, as the parent or legal guardian of the student named above, I understand that the Wellness Center will not provide x-rays, complex lab tests, services, or ongoing primary treatment of chronic medical or psychiatric conditions. I also understand and agree that my son/daughter has the right to be fully informed as to the facts about any new or existing illness, injury, or available treatment before beginning such treatment.

I understand that the Delaware Division of Public Health (“DPH”), a division of the Department of Health and Social Services, retains administrative authority over, and provides partial funding for, the Wellness Center. Designated Wellness Center 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 as well as in the United States. Such information mandated and required by law includes: sexually transmitted disease; laboratory data; births; deaths; adverse medication reactions; child abuse or neglect; and domestic violence. Other general information will also be sent to DPH for statistical tracking, but this information will be de-identified which means that my son’s/daughter’s name will be removed.

___________________
Parent/Legal Guardian Initial Here

I understand that my child may request that some or all health visits remain confidential. In accordance with Delaware law, Federal law and the HIPAA Privacy Rule, for me or anyone (including a parent or guardian) to gain access to medical records regarding such visits, a written authorization must be completed by the student specifying their release. I have had the opportunity to receive and review the Wellness Center Notice of Privacy Practices brochure.

___________________
Parent/Legal Guardian Initial Here

I understand that insurance may be billed for covered services.

___________________
Parent/Legal Guardian Initial Here

I understand 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 associated with my child’s care.

I acknowledge that all information requested on the registration Health History Form and this consent is accurate and complete. My son/daughter and I have read this form carefully and I understand that if I have any questions I may call the Wellness Center Coordinator for any explanation(s) before I sign this authorization.

___________________
Signature of Parent/Legal Guardian     Date

___________________
Print Name of Parent/Legal Guardian

___________________
Signature of Student     Date

___________________
Print Name of Student

___________________
Street Address

___________________
City    State    Zip Code

Consent Form # 5, Rep Health, HIV
Revised 5/18/11
A complete and accurate health history is needed in order for the staff to provide quality health care. Services will not be provided unless all sections of this form are complete. (PLEASE PRINT)

Student's Name: ___________________________ Date of Birth ___________________________

Address: ___________________________________________ City: __________________ State: _______ Zip Code: _________

Gender: ☐ Male ☐ Female Grade: _____ Age: _____ Social Security #: _____-____-_____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ White

Ethnicity: ☐ Mixed ☐ Native Hawaiian/Pacific Islander ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Student Phone #: (Home) ___________________________ Students Phone #: (Cell) ___________________________

Name of parent/guardian: __________________________

Parent Phone #: (Home) ___________________________ Parent Phone #: (Cell) ___________________________

Name of Student's Health Care Provider (Doctor): __________________________

Address: ___________________________ Phone: ___________________________

Date of last visit: ___________________________ Reason for last visit: ___________________________

☐ NO PHYSICIAN OR MEDICAL PROVIDER

INSURANCE INFORMATION IS REQUIRED.
If you have NO medical coverage please indicate below. Health insurance will be billed for your child’s Wellness Center visit. This information is required to process your child’s insurance claim.

PRIMARY MEDICAL INSURANCE
Name of Insurance Company: ___________________________

Insurance Address: ___________________________

Policy Number: ___________________________ Group Number: _______

Subscriber: ___________________________ Subscriber DOB: ___________________________ Relationship to child ___________________________

☐ Medicaid

☐ NO MEDICAL COVERAGE or SELF PAY

SECONDARY MEDICAL INSURANCE
Name of Insurance Company: ___________________________

Insurance Address: ___________________________

Policy Number: ___________________________ Group Number: _______

Subscriber: ___________________________ Relationship to child: __________________________

☐ Medicaid

PREFERRED PHARMACY: ___________________________ Phone #: ___________________________

Prescription Plan: ☐ Yes ☐ No

ALLERGIES
☐ No Allergies ☐ Drug/Latex Allergy: ___________________________

☐ Contact/Food Allergy: ___________________________

MEDICATION
Please list or attach an additional sheet with any medications your child is currently using:

<table>
<thead>
<tr>
<th>Name</th>
<th>Dose</th>
<th>Reason for use</th>
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PLEASE LIST ALL HOUSEHOLD MEMBERS:

Name  Age  Relationship to student
1. ________________________________________________________________
2. ________________________________________________________________
3. ________________________________________________________________
4. ________________________________________________________________
5. ________________________________________________________________

FAMILY HEALTH HISTORY
☐ High Blood Pressure  ☐ Diabetes (sugar)  ☐ Stroke
☐ Heart Disease/Heart Attack  ☐ Thyroid Disease  ☐ Asthma
☐ Kidney Disease  ☐ Sickle Cell  ☐ Tuberculosis
☐ High Cholesterol  ☐ Mental Health Concerns  ☐ Cancer
☐ Overweight

STUDENT HEALTH HISTORY

Please check ✔ any of the following illnesses or problems 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.

☐ Asthma  ☐ Anemia  ☐ Drug Use
☐ Thyroid Disorder  ☐ Ear Infections  ☐ Alcohol Use
☐ Sickle Cell Anemia  ☐ Kidney Disease  ☐ Smokes/Chews Tobacco
☐ Heart Problems  ☐ Colitis/Stomach Trouble  ☐ Learning Disability
☐ Ulcers/Reflux  ☐ Frequent Colds  ☐ Weight Concerns
☐ Fainting Spells  ☐ Tuberculosis  ☐ Eating Problem
☐ Diabetes  ☐ Hemophilia  ☐ Sleeping Problem
☐ Heart Problems  ☐ Chicken Pox  ☐ Frequent Anger
☐ Ulcers/Reflux  ☐ High Blood Pressure  ☐ Change in Friends
☐ Fainting Spells  ☐ Frequent Colds  ☐ Mood Changes
☐ Diabetes  ☐ Head Injury/Headaches  ☐ Appears Withdrawn
☐ Head Injury/Headaches  ☐ Mumps  ☐ Attempted Suicide
☐ Measles  ☐ Measles  ☐ Depression
☐ Physical Limitations  ☐ Measles  ☐ Other (Please List)
☐ Vision/Eye Problems  ☐ Mumps

Explanation of CURRENT illness or problems: __________________________________________________________

Do you have any worries or questions about your teen’s physical or emotional health:  ☐ Yes  ☐ No
If yes, what are your concerns? ________________________________________________________________

Has your teen ever received counseling or mental health services:  ☐ Yes  ☐ No
When: ____________________________  Name of Counselor/Facility: ____________________________
Type of services received: ________________________________________________________________

Has your teen used an Emergency Room in the last year:  ☐ Yes  ☐ No
If yes, how many times: __________  Reason(s): __________________________________________

Has your teen ever been hospitalized for more than one day or had surgery:  ☐ Yes  ☐ No
When: ____________________________  Which hospital: ____________________________
Reason for hospitalization/ or type of surgery: __________________________________________________________

Thank you for your interest and participation in this program. If you need assistance in completing these forms or have any questions, please do not hesitate to call the Wellness Center.

Milford High School Wellness Center  (302) 424-6120

Signature of Parent/Guardian: ____________________________  Date: ____________________________
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.

The terms of Notice may change. The most current Notice will always be posted in the Wellness Center. You may also contact the Wellness Center staff to obtain the most current copy.

STAFF AND STUDENT RESPONSIBILITIES

STAFF RESPONSIBILITIES

1) Center staff will provide each student with considerate, respectful, and appropriate care.

2) Each student will be informed of his/her medical condition(s), or counseling/nutritional plan. Each staff member will encourage students to talk with their family regarding their health concerns.

3) Center staff will not disclose information without student permission. Confidentiality, as required by law, will be maintained in all but the following circumstances:
   a. A student intends to harm self or others and there is a clear and immediate danger.
   b. Reporting child abuse of any kind.
   c. Reporting of certain contagious diseases to Division of Public Health.
   d. Response to legal subpoenas.

STUDENT RESPONSIBILITIES

1) Students with appointments must report to class first for attendance, teacher permission, and teacher signature on the pass.

2) Students are responsible for informing the Center in advance if they need to cancel an appointment.

3) It is expected that students do not congregate in the Center if they do not have appointments, and that they respect the privacy of others and property of the Center.

4) In keeping with standard medical practice, a health history and health risk assessment will be completed by each student accessing services at the Center. All information provided is confidential and will be used only as a means of assessing health risk behaviors.

5) Each student has the responsibility to answer questions honestly and provide all pertinent information concerning his/her health so that the most appropriate care can be planned.

6) Each student has the responsibility to make the health care provider aware if they have been given any information that they do not understand.

Signature of Parent: ___________________________ Date: ________________
Signature of Student: __________________________ Date: ________________