School-Based Health Wellness Center Consent Packet

Sponsored by
Rainelle Medical Center, Inc.

If you want your child to receive health services at the Wellness Center, please read carefully and complete the attached forms, sign in all places, and then return these completed forms to your child's homeroom teacher, or to the school office. We will not be able to see your child until we have this fully completed consent on file.

NAME OF CHILD: _____
DATE: _____

Please check one of the following:
_____I **give consent** for my child to receive health services at the Wellness Center.
_____I **do not give consent** for my child to receive health services at the Wellness Center.

Parent/Guardian: _____

For more information, please call Judy Koehler, Manager
School-Based Health Wellness Center
438-6188 ext. 1020

Revised June 22, 2007

Questions and Answers about our Wellness Center

What is a Wellness Center?

Wellness Centers are health centers based in a school and provide the students with medical, mental health, and health education services. School-based health centers work to improve the health of students, increase access to health care and decrease time lost from school by providing health care in the school. Services provided include: acute care for illness or injury, physical exams and sports physicals, medically prescribed laboratory tests, health education for students and parents, immunizations, follow-up for long term illnesses, individual, family and group mental health counseling.

Is it free?

The Rainelle Medical Center, Inc. (RMC) will bill private insurance, Medicaid and the Children's Health Insurance Program (CHIP) for eligible students, but parents will be responsible for co-payments and deductibles for medical services. Mental health or counseling services will have no out of pocket costs. You may apply through RMC for sliding fee to help cover costs. If you have any questions about billing or the sliding fee program, please contact our billing department at 438-6188. **Insurance changes must be forwarded to the Wellness Center as soon as possible to avoid any billing problems.**

Will signing up at the Wellness Center mean that we can't use our family doctor? If we have a family doctor, do we need the Wellness Center?

If you have a family doctor, you can still use the Wellness Center. You may find it convenient for your child to get medical care if they get sick or injured at school. Or you may want your child to be able to use the counseling and health education services offered through the Wellness Center. When we complete a physical exam or provide immunizations, we can send the results to your family doctor upon your request. This service is not meant to replace your family doctor, it is meant to complement the services your family doctor provides and to help students who do not have a family doctor. However, if you have Medicaid or private insurance with an assigned provider we may only be able to see your child once unless you change your primary care provider with your HMO to Rainelle Medical Center.

Can I select which services my child can use at the Wellness Center?

Yes. The Wellness Center services are listed on the consent form and there is space for you to write in which services you do not want your child to receive. Wellness Center staff will check your consent form before they see your child and will know which restrictions you have placed on your consent. Parents are always encouraged to contact the Wellness Center staff with questions or concerns and are welcome to accompany children to their visit.

Will my child's medical information be kept confidential?

Your child's medical information will be treated with strict confidentiality. If you would like the wellness center to discuss your child's condition with the school, please contact us. Otherwise, it is your responsibility to notify the school of any medications, allergies, or medical problems that may affect your child during school. By signing the consent form you are giving the wellness center and the county school nurses permission to communicate and share medical information regarding your child's medical condition on a needed basis and with the understanding that this information will continue to be treated in a confidential manner.

Who do I call for more information or to change insurance information?

Please call 438-6188 ext. 1020 with insurance changes, questions, suggestions or concerns, or to obtain information on applying for sliding fee, Medicaid or CHIP.

_____**Please initial that you have read this page.**

Revised June 26, 2007

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Wellness Center Parent Consent Form

Informed Consent for Health Services at the Wellness Center

Because young adolescents go through rapid physical and emotional changes, have significant risks to their health, and have problems getting to health services, we provide the following services:

A) Physical exams and sports physicals
B) Health care for illnesses
C) Follow-up for long term illnesses
D) Medically-prescribed laboratory tests
E) Dental referrals
F) Health Education for students/parents
G) Immunizations
H) Individual, family and group mental health counseling/therapy

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If you want your child to receive health services at the Wellness Center, please read this form carefully, complete the questions and sign.

NAME OF CHILD: _____

(Please list child's name as it appears on birth certificate)

_____ _____ _____
Parent/Guardian Name (please print) Relationship to Child Date

_____
Mailing Address City State Zip

_____ _____ _____
Home Phone Number Cell Phone Number Work Phone Number
May we contact you at work? Yes No

Student's Birth Date: ____/____/____ Grade: _____ Social Security Number: __ __ __/__ __/__ __ __ __
(It is very important that we have this number)

Sex (circle): Male Female Race (circle): White Black Other

Please list an alternate contact (adult relative or friend) that will know how to contact you in case of an emergency.

Name of Alternate Contact: _____ Relationship to Child: _____
Contact's Phone Number: _____

The following information will help the Health Provider evaluate your child's health. Please answer to the best of your knowledge.

1. Is your child allergic to any medications? Yes____ No____ If yes, what? _____
   _____
   Does your child have any other allergies? (Such as foods, pollens, insect bites, etc.) Yes_____No____ If yes, what?
   _____

2. List any medications your child is taking now and reason for which the medicine was given:

Medication/Dose	Reason	How Long Taking Medication
_____	_____	_____
_____	_____	_____

3. Has your child ever had any serious or sports related injuries or been hospitalized overnight? Yes_____ No_____
   If yes, explain: _____

4. Has there been any change in your child's health during the past year? Yes_____ No_____ If yes, give the age and describe the illness or injury: _____

5. Has your child ever received mental health counseling services? Yes____ No____ If yes, when? _____ With whom? _____

6. Please check if your child ever had any of the following health problems and state at what age the problem started:

	Yes	Age		Yes	Age
Allergies	____	____	Pneumonia	____	____
Anemia or blood disorders	____	____	Rheumatic Fever/Heart Disease	____	____
Asthma	____	____	Scoliosis	____	____
Bladder or kidney infections	____	____	Seizures	____	____
Cancer	____	____	Severe Acne	____	____
Chicken Pox	____	____	Sports injuries or fractures	____	____
Diabetes	____	____	Thyroid Disease	____	____
Endocrine/Gland Disease	____	____	Tuberculosis	____	____
Hepatitis	____	____	Ulcer or digestive problems	____	____
Headaches/Migraines	____	____	Mental illness or depression	____	____
Mononucleosis	____	____	Other	____	____

7. Immunizations: **Please attach a copy of your child's Immunization Record.**
   When was your child's last DPT or TDAP shot? Month/Year: ___/___
   Last measles, mumps, rubella (MMR)? Month/Year ___/___
   Has your child been vaccinated against Hepatitis B? (Please note this is NOT the "HIB" vaccine.) Yes___ No___
   If yes, please indicate the approximate dates. Month/Year: 1st ____/____, 2nd ____/____, 3rd _____/____
   Has your child been vaccinated for meningitis? Yes___ No___ Date_____
   Has your child been vaccinated for human papillomavirus? Yes ___ No___ (females only)
   If yes, Month/Year 1st___/___, 2nd___/___, 3rd___/___
   Has your child been vaccinated for varicella (chicken pox)? Yes___ No___ Date _____

8. Please check if you or any of your child's *blood* relatives (parents, grandparents, aunts, uncles, brothers or sisters), living or deceased, had any of the following problems. Please state the relative's relationship to your child.

Condition	Yes	Relationship	Condition	Yes	Relationship
Alcoholism/Drugs	____	_____	High Cholesterol	____	_____
Allergies/Asthma	____	_____	High Blood Pressure	____	_____
Arthritis	____	_____	Kidney Disease	____	_____
Birth Defects	____	_____	Lung Disease/	____	_____
Blood Disorders/	____	_____	Tuberculosis	____	_____
Sickle Cell Anemia	____	_____	Mental Health/Depression	____	_____
Cancer (type_____)	____	_____	Mental Retardation	____	_____
Diabetes	____	_____	Obesity	____	_____
Endocrine/Gland Disease	____	_____	Seizures/Epilepsy	____	_____
Heart Attack	____	_____	Stroke before age 55	____	_____

9. With whom does the child live most of the time? Check all that apply:
   _____Both parents in same household ____Mother ____Father
   _____Stepfather ____Stepmother ____Brother(s)/ages: _____
   _____Guardian ____Alone ____Sister(s)/ages: _____
   _____Other: _____

10. In the past year, have there been any changes in your family such as:
    _____Marriage _____Serious illness _____Change in school _____Moved to a new home
    _____Separation _____Loss of job _____Births _____Divorce
    _____Deaths _____Other: _____

11. How often does your child go to the dentist? At least once a year: ____Only with toothaches: _____Never: _____
When was your child's last dental exam? _____Name of dentist: _____

12. Are there smokers in your house? Yes: ____ No: ____

13. Does your child have a family doctor or pediatrician? Yes: ____ No: ____ If yes, please list your medical provider's name: _____. When did your child have his/her last *complete* physical exam? _____
Please initial here if you would like your child to have a physical exam:
__My child has not had a physical exam within the last year. If time allows, I would like my child to have a physical exam during the school year.

14. Some parents or guardians have questions or concerns about their child's development. Please review the topics listed below and check any concerns you may have about <u>your</u> son or daughter:

Physical complaints	_____	Violence	_____
Physical development	_____	School grades/truancy/dropout	_____
Weight	_____	Smoking cigarettes/chewing tobacco	_____
Change of appetite	_____	Drug use	_____
Sleep patterns	_____	Alcohol use	_____
Diet/Nutrition	_____	Dating/parties	_____
Amount of physical activity	_____	Sexual behaviors	_____
Emotional development	_____	HIV/AIDS	_____
Relationships w/family members	_____	Birth control	_____
Choice of friends	_____	Sexual identity (Heterosexual/homosexual)	_____
Self-image/self worth	_____	Work or job	_____
Excessive moodiness or rebellion	_____	Lying, stealing or vandalism	_____
Depression	_____	Other: _____	_____

15. Does your child have a current or chronic health condition? Yes_____ No_____
16. Does your child have any special needs (physical handicap, learning disabilities, special dietary needs, etc.)? Yes____ No____
If yes to questions 15 or 16, please explain._____

If we need to call in a prescription for your child, which pharmacy would you like us to call?
_____

The above information is accurate and complete to the best of my knowledge. I have completely disclosed all known allergies, chronic illnesses, prior medications or drugs that have resulted in adverse reactions, and current medications with respect to my child. By signing below, I authorize my child to be seen at the Wellness Center. I agree to all services listed on page one **<u>except</u>** what I have listed below.

I <u>do not</u> want my child to receive the following services: _____
_____
_____

I authorize the Wellness Center staff to release information regarding treatment to third party payors, such as Medicaid, CHIP and private insurance for billing purposes. ***I understand that this consent form will be valid until my child leaves/graduates school or until I provide the Wellness Center staff with written directions otherwise.*** I am the legal guardian of the above named child. I understand that a new consent form must be signed by the legal guardian if guardianship would change and that if I am not this child's birth parent, it is necessary to attach a copy of proof of legal guardianship.

_____ _____
Parent/Guardian Signature **Date**

_____
Relationship to Child