# HOWARD COUNTY HEALTH DEPARTMENT
# SCHOOL-BASED WELLNESS CENTER PROGRAM
## Parent/ Guardian Consent Form

## STUDENT INFORMATION

**Last Name**: _____

**First Name**: _____

**Address**: _____

_____
*City* *State* *Zip Code*

**Date of Birth**: _____/_____/_____
*Month* *Day* *Year*

**Sex**: ❑ Male ❑ Female

❑ Transgender Male ❑ Transgender Female

❑ Non-Binary_____

**Social Security Number (optional):** _____

**Race / Ethnicity**: ❑ Hispanic ❑ Black ❑ White

❑ Native American ❑ Asian/Pacific Islander

❑ Other _____

**Preferred Language**: _____

**Name of School:** _____

**Grade:** _____

## PARENT/GUARDIAN INFORMATION

**Mother**
Last Name: _____First Name:_____

Contact Number(s): _____

E-mail Address: _____

**Father**
Last Name: _____ First Name:_____

Contact Number(s): _____

E-mail Address: _____

**Legal Guardian, If Applicable**

Last Name: _____First Name:_____
Relationship of legal guardian to student:
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Number(s): _____

E-mail address: _____

**Additional Emergency Contact**

Name: _____

Relationship to Student: _____

Contact Number(s):_____

## HEALTH INSURANCE INFORMATION

**Does your child have Medical Assistance?** ❑ No ❑ Yes **Private Insurance?** ❑ No ❑ Yes **No Insurance?** ❑ No ❑ Yes

If Medical Assistance, please provide the following information**.** **Medical Assistance #**_____ and
**Patient ID #** _____

**Which health insurer does your child receive health services through? Please check the appropriate box below:**
❑ AMERIGROUP ❑ Maryland Physicians Care ❑ Riverside ❑ Jai ❑ Medstar ❑ United Healthcare-Community Plan

❑ Kaiser Permanente ❑ Priority Partners

If your child does not have health insurance, would you like the Howard County Health Department staff contact and assist you with applying for health insurance? ❑ No ❑ Yes

**Please turn this page over, read, sign and date on the two designated lines.**
**Thank you!**

**IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.**

# HOWARD COUNTY HEALTH DEPARTMENT
# SCHOOL-BASED WELLNESS CENTER PROGRAM
## Parental Consent Form

**Child's Name:** **School:**

## SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals of the Howard County Health Department School Based Wellness Center. School-Based Wellness Center services may include, but are not limited to:

- Health screening and comprehensive physical examinations (complete medical examination) including those for EPSDT, school and sports
- Medically prescribed, basic laboratory tests which may include venipuncture and testing of other body fluids, such as urine or throat and wound secretions, for conditions including anemia, strep throat, and diabetes
- Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
- Mental health services including evaluation, diagnosis, treatment, and referrals, if provided at Wellness Center
- Referrals for service not provided at the school-based wellness center
- Annual health questionnaire/survey and health education and risk preventions counseling

**X**_____ _____

**Signature of Parent/Guardian** **Date**

## HOWARD COUNTY HEALTH DEPARTMENT'S
## FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
## HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical information for the Howard County Health Department School-Based Wellness Center to contact other providers that have examined my child to release any medical or other information to assist in the management of my child's health. This information may be protected from disclosure by federal privacy law and state law.

By signing this consent, I am authorizing medical information to be given to the Howard County Public School System either because it is required by law or because it is necessary to protect the health and safety of the student. Upon my request, the facility or person disclosing this medical information must provide me with a copy of this form. Parents are required by law to provide certain information to the school, such as proof of immunization. Failure to provide this information may result in the student being excluded from school.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information and that I can change my mind at any time and revoke my authorization by writing to the School-Based Wellness Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

**I consent to the release from the Howard County Health Department School Based Wellness Center to the Howard County Public School System and from the Howard County Public School System to the Howard County School-Based Wellness Center, of medical information outlined below in order to meet regulatory requirements and ensure that the school has information needed to protect my child's health and safety. I understand that this information will remain confidential in accordance with Federal and State law regulations on confidentiality:**

**Information Required by Law or School System:**
- New entrant exam
- Immunization record
- Vision and hearing screening results
- Tuberculin test results

**Information to Protect Health and Safety**:
- Conditions which may require emergency medical treatment
- Mental health conditions including evaluations, diagnosis, treatment
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Conditions which limit a student's daily activity
- Health insurance coverage

**PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:**
I, the undersigned, voluntarily consent to treatment of my child by the provider and staff of the Howard County Health Department School Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I authorize payment directly to the HCHD for services for which HCHD accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

**X**_____ _____

**Signature of Parent/Guardian** **Date**

Time Period During Which Release of Information is Authorized:
**From**: Date that form is signed **To**: Date that student is no longer enrolled in the School-Based Wellness Center

**IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.**