

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

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p>Last Name: _____</p> <p>First Name: _____</p> <p>Address: _____</p> <p align="center">_____ <i>City State Zip Code</i></p> <p>Date of Birth: ____/____/____ <i>Month Day Year</i></p> <p>Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>Social Security Number: -- --</p> <p>Race / Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Black <input type="checkbox"/> White <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other _____</p> <p>Preferred Language: _____</p> <p>Name of School: _____</p> <p>Grade: _____</p>	<p>Mother Last Name: _____ First Name: _____</p> <p>Contact Number(s): _____</p> <p>E-mail Address: _____</p> <p>Father Last Name: _____ First Name: _____</p> <p>Contact Number(s): _____</p> <p>E-mail Address: _____</p> <p>Legal Guardian, If Applicable Last Name: _____ First Name: _____ Relationship of legal guardian to student: <input type="checkbox"/> Grandparent <input type="checkbox"/> Aunt or Uncle <input type="checkbox"/> Other: _____</p> <p>Contact Number(s): _____</p> <p>E-mail address: _____</p> <p>Additional Emergency Contact Name: _____ Relationship to Student: _____ Home Tel: _____ Work Tel: _____ Cell: _____</p>

HEALTH INSURANCE INFORMATION

Do you have Private or Employer Based Health Insurance: No Yes (If yes, complete the following section)

Insurance Company's Name: _____ Primary Insurance: No Yes

Name of Policyholder and their Date of Birth: _____ D.O.B.: _____

Relationship to Child: _____

Member's Identification Number: _____ Group Number: _____

Does your child have Medical Assistance? No Yes
If yes, please provide the following information. Medical Assistance # _____

If your child receive health services through a MCO 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, please provide:
Annual Family Income: _____ **# of Family Members:** _____

If your child does not have health insurance, would you like Connector Entity staff from the Door To Healthcare contact you to enroll into health insurance? No Yes

Please turn this page over, read, sign and date it.

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. I understand that confidentiality between the student and the health provider will be ensured in specific service areas in accordance with the law, and that pupils will be encouraged to involve their parents or guardians in counseling and medical care decisions. 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 accept that I am financially responsible for all services rendered to my child. For those insurance plans for which Howard County Health Department (HCHD) accepts assignment, I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. 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

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.