

**THE WELLNESS CENTER AT MILFORD HIGH SCHOOL**  
**PARENT/STUDENT CONSENT FOR TREATMENT**

I, \_\_\_\_\_, give my consent for \_\_\_\_\_  
(Name of Parent/Guardian of Student) (Name of Student)  
to receive services at the Wellness Center, administered by Bayhealth Medical Center, located at Milford High School.

***If you wish to decline a service listed for your child, CROSS OUT that specific service.***

**Physical Health**

- Assessment, diagnosis and treatment of minor illness/injury (may include urinalysis, throat culture, dispensing non-prescriptive medication and/or providing prescription medication)
- Identification and referral for treatment, to student's Primary Care Provider, for conditions such as high blood pressure, diabetes and asthma
- Athletic, Employment, Routine Physical (may include a urinalysis and vision screen)
- Immunizations (Tetanus, Hepatitis B vaccine, etc.) and routine tuberculin screening (PPD)
- Pregnancy Testing
- Diagnosis and Treatment of Sexually Transmitted Infections
- Assistance in linking to medical provider, dentist or health insurance
- Coordinate services with student's Primary Care Provider, as needed

**Counseling/Emotional Health**

- Stress Management, Individual, and/or Group Counseling
- Drug, Alcohol and substance abuse counseling and referral
- Referral for long term counseling and evaluation

**Education**

- Individual and group health education
- HIV/AIDS Education
- Smoking prevention and cessation
- Anger Management
- Responsible decision making

**Nutrition**

- Sports Nutrition
- Weight Management through healthy eating and exercise
- Specialized diets/Healthy eating
- Prenatal and Post-partum nutrition

**THE WELLNESS CENTER DOES NOT PROVIDE THE FOLLOWING SERVICES:** Distribution or prescribing birth control or condoms, treatment or testing of complex medical or psychiatric conditions, x-rays, hospitalization

**BY SIGNING THIS CONSENT. I UNDERSTAND AND AGREE WITH THE FOLLOWING:**

- Visits to the Wellness Center will be strictly confidential
- Access to the student's medical records or telephone calls regarding the student require written consent by the student
- Health information can be shared, as needed, between the Wellness Center staff, school nurse, and guidance office
- A copy of the DIAA (sports physical) form will be shared with the athletic director to determine eligibility
- Consent for services may be withdrawn at any time by the parent/guardian
- I have read this form and provided complete and accurate information and health history
- Services are provided at no cost
- I may contact the Wellness Center to receive a copy of the Notice of Privacy Practices

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date



## THE WELLNESS CENTER AT MILFORD HIGH SCHOOL HEALTH HISTORY FORM

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)

Name of parent/guardian signing form \_\_\_\_\_ Work phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Student's Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Home phone # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Male  Female      Grade \_\_\_\_\_ Age \_\_\_\_\_      Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Race:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> African Am/Black | <input type="checkbox"/> Hispanic/AfricanAm/Black | <input type="checkbox"/> Hispanic/Native Hawaiian/Pacific |
| <input type="checkbox"/> White            | <input type="checkbox"/> Hispanic/White           | <input type="checkbox"/> Native Hawaiian/Pacific Islander |
| <input type="checkbox"/> Asian            | <input type="checkbox"/> Hispanic/Asian           | <input type="checkbox"/> Mixed                            |
| <input type="checkbox"/> American Indian  | <input type="checkbox"/> Hispanic/American Indian | <input type="checkbox"/> other                            |

**Who lives at student's home (father, mother, sister, brother) and how old are they?**

	Name	Relationship to student	Age
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

Name of child's Health Care Provider (Doctor) \_\_\_\_\_

	Name	City	State	Phone Number
Address _____	_____	_____	_____	Zip _____

Date of last visit? \_\_\_\_\_ Reason for last visit? \_\_\_\_\_

\_\_\_\_ Please check  if your child does not have a Physician/Medical Provider

Has your teen ever been hospitalized for more than one day or had surgery? No \_\_\_ Yes \_\_\_

When? \_\_\_\_\_ Which hospital? \_\_\_\_\_

Reason for hospitalization/or type of surgery? \_\_\_\_\_

Has your teen used an Emergency Room in the last year? No \_\_\_ Yes \_\_\_ If yes, how many times? \_\_\_\_\_

Reason (s)? \_\_\_\_\_

Has your teen ever received counseling services or inpatient mental health treatment? No \_\_\_ Yes \_\_\_

When? \_\_\_\_\_ Name of Counselor/Facility \_\_\_\_\_

Type of services received \_\_\_\_\_

**Immunization Dates:**

Tetanus Booster _____	Hepatitis B #1 _____	HPV #1 _____
Meningitis _____	Hepatitis B #2 _____	HPV #2 _____
Chicken Pox _____	Hepatitis B #3 _____	HPV #3 _____

Please list any **ALLERGIES** to **Medications/Food/Latex** your child has \_\_\_\_\_

Please list any **MEDICATION** your child **currently** is taking:

Name of Medication	Dose	Reason for Taking

**Please check  if any family members (parents, brothers, sisters, grandparents, aunts, uncles) have any of the following problems or have had them in the past? If yes, indicate which family member(s) next to appropriate illness:**

_____ High Blood Pressure	_____ Diabetes (sugar)	_____ Stroke
_____ Heart disease/Heart Attack	_____ Thyroid Disease	_____ Asthma
_____ Kidney Disease	_____ Sickle Cell	_____ Tuberculosis
_____ High Cholesterol	_____ Mental Illness	_____ Cancer _____
_____ Overweight		(type or site)

**Please check  any of the following illnesses or problems that your child has now or has had in the past. Indicate with P=Past or C=Current. Please provide details below for any CURRENT problem.**

_____ 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	_____ Eating Problem
_____ Fainting Spells	_____ Tuberculosis	_____ Weight Concerns
_____ Diabetes	_____ Hemophilia	_____ Sleeping Problem
_____ Head Injury/Headaches	_____ Chicken Pox	_____ Change in Friends
_____ Seizures	_____ High Blood Pressure	_____ Mood Changes
_____ Mumps	_____ Arthritis	_____ Appears Withdrawn
_____ Measles	_____ Skin Problems	_____ Attempted Suicide
_____ Physical Limitation	_____ Menstrual Problems	_____ Depression
_____ Vision/Eye Problems	_____ Personal Hygiene	_____ Frequent Anger
		_____ other (Please describe)

**Explanation of any CURRENT problem(s):** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness Center to address? No \_\_\_ Yes \_\_\_ If so, please explain in detail below.**

\_\_\_\_\_  
\_\_\_\_\_

**The above medical information is accurate and complete.**

**Signature of Parent/Legal Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

# THE WELLNESS CENTER AT MILFORD HIGH SCHOOL 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 may be referred to the Wellness Center by the School Nurse, and/or Guidance Department, except for sports physicals, then staff, students, or parents may refer.
- 2) Students with appointments must always report to class first for attendance, teacher permission, and teacher signature on the pass.
- 3) Students are responsible for informing the Center in advance if they need to cancel an appointment.
- 4) 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.
- 5) In keeping with standard medical practice, students using the Center will be asked to complete a health risk assessment. All information provided is confidential and will be used only as a means of assessing health risk behaviors. Care will be provided using this tool in conjunction with the parent completed Health History.
- 6) 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.
- 7) Each student has the responsibility to make the health care provider aware if they have been given any information that they do not understand.
- 8) Parents wishing to have their teen seen at the Wellness Center should first contact the school nurse or guidance counselors for a referral.

I have read and understand the Wellness Center staff and student responsibilities.

\_\_\_\_\_  
Student Signature                      Date

\_\_\_\_\_  
Staff Signature                      Date



**The Wellness Center at Milford High School**  
**1019 N. Walnut Street • Milford, DE 19963**  
**(302) 424-6120**

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT  
BAYHEALTH SCHOOL BASED WELLNESS CENTERS**

Effective April 14, 2003, the Wellness Center must comply with the Privacy 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.

\_\_\_\_\_ Please check  if you would like to be provided with a copy of the Notice of Privacy Practice.

I hereby acknowledge that I have read the above information and been offered a copy of the Wellness Center’s Notice of Privacy Practices.

\_\_\_\_\_  
**Student Signature**

\_\_\_\_\_  
**Date**

9/07