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

HOWARD COUNTY HEALTH DEPARTMENT SCHOOL-BASED WELLNESS CENTER

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

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

Student's Social Security Number: _____

Sex: ❑ Male ❑ Female Grade _____

Race/ Ethnicity: ❑ Hispanic ❑ Black ❑ White
❑ American Indian ❑ Asian/Pacific Islander
❑ Other _____

Student's Address:_____
_____
_____ _____ _____
City State Zip Code

Who is the student's regular health provider?

Name: _____

Telephone: _____

Address: _____
_____

Student's School_____

PARENT/GUARDIAN INFORMATION

Mother
Last Name: _____First Name: _____

Father
Last Name: _____ First Name: _____

Legal Guardian, If Applicable
Last Name: _____First Name: _____
Relationship of legal guardian to student
❑ Grandparent ❑ Aunt or Uncle ❑ Other: _____

Contact Information for Parent or Guardian
Home Tel: _____Work Tel: _____
Cell: _____

Additional Emergency Contact
Name: _____
Relationship to Student: _____
Home Tel: _____ Work Tel: _____
Cell: _____

HEALTH INSURANCE INFORMATION

Does your child have Medical Assistance?

❑ No ❑ Yes: Medical Assistance #_____

Does your child receive health services through a MCO or HMO?
❑ No ❑ Yes- Please check the appropriate box below.

Which Plan?
❑ AMERIGROUP ❑ Maryland Physicians Care ❑ Riverside
❑ Diamond ❑ Medstar ❑UnitedHealthcare
❑ Jai ❑ Priority Partners
❑ Other: _____

Does your child have other health insurance?

❑ No ❑ Yes: Company's Name: _____

Name of Person Listed on Insurance Card:
_____

Member's Identification Number:
_____

If your child does NOT have health insurance, please provide:
Annual Family Income:_____ # of Family Members:____

PARENTAL CONSENT FOR SCHOOL-BASED WELLNESS CENTER SERVICES

I have read and understand the services listed on the next page (School-Based Wellness Center Services) and **my signature provides consent for my child to receive services provided by the HOWARD COUNTY HEALTH SCHOOL-BASED WELLNESS CENTER**.
NOTE: **My signature indicates I have received a copy of the Howard County Health Department Notice of Privacy Practices.**

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.

X _____ _____
Signature of Parent/Guardian *(or student if 18 years or older or otherwise permitted by law)* **Date**

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT

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

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:

1. Health screening and comprehensive physical examinations (complete medical examination) including those for EPSDT, school and sports
2. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes
3. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
4. Mental health services including evaluation, diagnosis, treatment, and referrals
5. Referrals for service not provided at the school-based wellness center
6. Annual health questionnaire/survey

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 the reverse side of this form authorizes release of medical information. 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 authorize the Howard County Health Department School Based Wellness Center to release specific medical information of the student named on page one to the Howard County Public School System.

I authorize the administration of Albuterol nebulizer treatments, administering of acetaminophen or ibuprofen if medically indicated.

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
- Conditions which limit a student's daily activity
- Diagnosis of certain communicable diseases (not including HIV infection/STI and other confidential services protected by law)
- Health insurance coverage

My signature on page one of this form also gives my consent to 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 or to process insurance claims.

<u>Time Period During Which Release of Information is Authorized</u>:

From: Date that form is signed on opposite page
To: Date that student is no longer enrolled in the School-Based Wellness Center

PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT