

WASHINGTON COUNTY PUBLIC SCHOOLS  
Hagerstown, Maryland 21740

**PARENTAL CONSENT FORM FOR SCHOOL BASED WELLNESS CENTER**

I am granting permission for my child to enroll in the School-Based Wellness Center and consent to his/her receiving health related services which may include physical examinations, health screening, limited diagnostic tests (e.g., throat cultures), education, counseling, referrals, and administration of necessary medications. You have my permission to obtain/release any Wellness Center information to/from my child's health care provider, MCO, Mental Health Provider, School Health Staff, and the school's staff when needed to coordinate care.

- **I understand that I am responsible for co-payment or deductible required by my private insurance, and may be responsible for payment for services received that are not covered by my insurance. A sliding scale is available for the students who meet eligibility criteria based on family size and income.**
- I understand that the Wellness Center program can supplement the care provided by my private medical provider as long as my child attends this school or another school with School Based Wellness Center services.
- I understand that I am responsible for medical care if follow-up outside the school-based center is recommended.
- I understand that if my child is registered with Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school health center.
- I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, and drug abuse without further parental consent per annotated code of Maryland (COMAR).
- I understand that Maryland Law allows a minor 16 years of age or older to receive treatment and/or advice about mental health without further parental consent per COMAR.
- I understand my child may participate in a Risk Assessment Survey. If you have any questions regarding content of the survey, please contact the Washington County Health Department at 240-313-3244.

Print Your Child's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Race: \_\_\_\_\_ Grade: \_\_\_\_\_

Child's Address: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Child's Social Security Number: \_\_\_\_\_  Male  Female

Child's Doctor: \_\_\_\_\_ Telephone: (\_\_\_\_\_) \_\_\_\_\_

School: \_\_\_\_\_

Telephone: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

Does your child have health insurance?  Yes  No

**If your child has Medical Assistance, please complete the following information:**

Child's Medical Assistance Number \_\_\_\_\_

Name of MCO: \_\_\_\_\_

**If your child's health care is covered by private insurance, please copy ALL of the following information DIRECTLY from your insurance card AND/OR attach a copy of that card to this form (FRONT AND BACK).**

1. Insurance Company's Name and Claims Address: \_\_\_\_\_

Insurance Company's Phone Number: (\_\_\_\_\_) \_\_\_\_\_

2. **Name of Individual listed on Insurance Card:** \_\_\_\_\_ **Relationship to child:** \_\_\_\_\_

Policy Number of Insured Listed on Card: \_\_\_\_\_

Group Number Listed on Health Insurance Card: \_\_\_\_\_

3. List the name of the Policy Holder (person whose name the Insurance policy is under): \_\_\_\_\_

Social Security Number of Policy Holder: \_\_\_\_\_

**SIGNATURE OF PARENT/LEGAL GUARDIAN** \_\_\_\_\_

DATE \_\_\_\_\_

Relationship to Student: \_\_\_\_\_