

**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 can include physical examinations, health screening, risk assessment surveys, limited diagnostic tests, (e.g., throat cultures, blood work), education, counseling, referrals, and administration of necessary medications. School-Based Wellness Center staff will have access to the Wellness Center records. You have my permission to release any Wellness Center information to my child's health care provider, MCO, Mental Health Provider, and the school's Guidance Counselor when needed to coordinate care.

- **NO CHILD WILL BE DENIED SERVICES BECAUSE OF INABILITY TO PAY.**
- I give permission to bill my insurance **with the understanding that I will not be responsible for any additional payment.**
- 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.
- 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 a Managed Care Organization (MCO) through Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school health center. The health center will send information about the visit to my child's primary care provider and to the MCO for billing purposes.
- 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 survey, please contact the Washington County Health Department at 240-313-3462.

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

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

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

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

School \_\_\_\_\_

**Signature of Student:** \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship to Student: \_\_\_\_\_ Telephone: (H) ( ) \_\_\_\_\_ (W) ( ) \_\_\_\_\_

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

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

Child Receives MA Services through a MCO: Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, 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 or attach a copy of that card to this form.**

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

Insurance Company's CLAIMS (Billing) Address (if different from above) \_\_\_\_\_

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

2. Name of Individual listed on Insurance Card \_\_\_\_\_

Policy Number of Insured Listed on Card (may be social security number) \_\_\_\_\_

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 \_\_\_\_\_

Place of Employment of Policy Holder \_\_\_\_\_

Work Phone Number: ( ) \_\_\_\_\_

Relationship of Policy Holder to Child \_\_\_\_\_

Home Address of Policy Holder \_\_\_\_\_

**If your child has no health care coverage through an MCO, Medical Assistance, or private insurance, please indicate by placing a check in this space:**

\_\_\_\_\_ **Would you like to receive an application for MCHP (Maryland Children's Health Program)?** \_\_\_\_ yes \_\_\_\_ no

**FOR OFFICE USE ONLY: HEALTH INFO UPDATE SENT:**