SCHOOL-BASED WELLNESS CENTER
PARENT/STUDENT CONSENT FOR TREATMENT

I, _____, give my consent for_____
(Parent/Legal Guardian of Student) **(Name of Student)**

to receive the health services at the _____Wellness Center
(Name of High School)

administered by: _____ Telephone Number: _____
(Name of Medical Vendor)

Please circle either Yes or No if you want your child to receive the following services

MENU OF SERVICES	**CONSENT GIVEN**
PHYSICAL HEALTH	**(CIRCLE ONE)**
• Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury (May include a urinalysis, throat culture, limited blood test or medically indicated pregnancy testing, dispensing non prescription medication and/or providing prescription medication)	YES NO
• Physical examinations, including sports/employment physical	YES NO
• Immunizations in accordance with the Division of Public Health	YES NO
• Coordinating services with student's Primary Health Care Provider /other Provider	YES NO
• Diagnosis and treatment of sexually transmitted diseases	YES NO
• Referral of a student who does not have a primary care provider to a physician	YES NO
• Drug, alcohol and other substance abuse counseling and referral	YES NO
• HIV testing and counseling	YES NO
• Nutrition counseling	YES NO
MENTAL HEALTH	
• Individual counseling	YES NO
• Group counseling	YES NO
• Family counseling	YES NO
• Referrals for long-term counseling or other evaluations	YES NO
EDUCATION	
• Individual and group programs focusing on healthy life choices	YES NO

The Wellness Center does not provide the following services

- Treatment or testing of complex medical or psychiatric conditions
- Ongoing primary treatment of chronic medical conditions
- Reproductive Health
- Complex lab tests
- Hospitalization
- X-Rays

PLEASE COMPLETE OTHER SIDE

By my signature below I certify, as the parent or legal guardian of the student named above, I understand that the Wellness Center will not provide x-rays, complex lab tests, services, or ongoing primary treatment of chronic medical or psychiatric conditions. I also understand and agree that my son/daughter has the right to be fully informed as to the facts about any new or existing illness, injury, or available treatment before beginning such treatment.

I understand that the Delaware Division of Public Health ("DPH"), a division of the Department of Health and Social Services, retains administrative authority over, and provides partial funding for, the Wellness Center. Designated Wellness Center Team members are obligated by law to disclose specific patient information to DPH, for the purpose of preventing or controlling disease, injury, surveillance, or disability in Delaware as well as in the United States. Such information mandated and required by law includes: sexually transmitted disease; laboratory data; births; deaths; adverse medication reactions; child abuse or neglect; and domestic violence. Other general information will also be sent to DPH for statistical tracking, but this information will be de-identified which means that my son's/daughter's name will be removed. _____
Parent/Legal Guardian Initial Here

I understand that my child may request that some or all health visits remain confidential. In accordance with Delaware law, Federal law and the HIPAA Privacy Rule, for me or anyone (including a parent or guardian) to gain access to medical records regarding such visits, a written authorization must be completed by the student specifying their release. I have had the opportunity to receive and review the Wellness Center Notice of Privacy Practices brochure. _____
Parent/Legal Guardian Initial Here

I understand that insurance may be billed for covered services. _____
Parent/Legal Guardian Initial Here

I understand this consent may be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the Wellness Center associated with my child's care.

I acknowledge that all information requested on the registration Health History Form and this consent is accurate and complete. My son/daughter and I have read this form carefully and I understand that if I have any questions I may call the Wellness Center Coordinator for any explanation(s) before I sign this authorization.

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Student Date

_____
Print Name of Student

_____
Street Address

_____
City State Zip Code