HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL BASED WELLNESS CENTER PROGRAM
Parent/ Guardian Consent Form

SCHOOL BASED WELLNESS CENTER TELEMEDICINE PROGRAM

STUDENT INFORMATION

Last Name: ____

First Name: ____

Address: ____

____
City *State* *Zip Code*

Date of Birth: ___________/__________/__________
Month *Day* *Year*

Sex: ❑ Male ❑ Female

Social Security Number: ______ -- ______ -- ______

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

Preferred Language: __________________________________

Name of School: _____________________________________

Grade: _____________

PARENT/GUARDIAN INFORMATION

Mother
Last Name: ___________________First Name:______________

Contact Number(s): ____________________________________

E-mail Address: _______________________________________

Father
Last Name: __________________ First Name:_____________

Contact Number(s): ____________________________________

E-mail Address: _______________________________________

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

Contact Number(s): ____________________________________

E-mail address: _______________________________________

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?
❑ No ❑ Yes - Please check the appropriate box below.

Which Plan?
❑ AMERIGROUP ❑ Maryland Physicians Care ❑ Riverside

❑ Jai ❑ Medstar ❑ United Healthcare

❑ Kaiser Permanente ❑ Priority Partners

❑ Other: ____________________________

If your child does NOT have health insurance, please provide:
Annual Family Income: _________ **# of Family Members:** ______

If your child does not have health insurance, would you like Connector Entity staff from the Door To Healthcare contact you to enroll into health insurance? ☐ No ☐ Yes

Does your child have private or employer-sponsored health insurance? ❑ No ❑ Yes

Company's Name: ______________________________________
Name of Policyholder and their Date of Birth:
__________________________________ D.O.B.___________
Relationship to Child: __________________________________
Member's Identification Number: _________________________
Group Number: ______________________

Does your child have another health insurer? ❑ No ❑ Yes
Company's Name: ______________________________________
Name of Policyholder and their Date of Birth:
__________________________________ D.O.B.___________
Relationship to Child: __________________________________
Member's Identification Number: _________________________
Group Number: _______________________________________

Please turn this page over, read, sign and date it.

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.

HOWARD COUNTY HEALTH DEPARTMENT
SCHOOL BASED WELLNESS CENTER TELEMEDICINE PROGRAM
Parent/ Guardian Consent Form

Child's Name: **School:**

SCHOOL-BASED WELLNESS CENTER SERVICES

I consent for my child to receive health care services provided by the State-licensed health professionals contracting withthe Howard County Health Department (HCHD) which may include the primary health careprovider I specified when enrolling my child in the HCHD School Based Wellness Center Program (SBWC) if the provider is part of the HCHD SBWC telemedicine network or another licensed health professional.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 telemedicine services may include, but are not limited to:

- Medical care and treatment, including diagnosis of acute and chronic illness and disease
- Prescribing of medications and if ordered by licensed health provider and medically-indicated, the dispensing of acetaminophen, ibuprofen, hydrocortisone cream 1% , and albuterol via inhaler or nebulization on-site
- Medically prescribed,basic laboratory tests for strep throat (Rapid strep and throat culture)
- Referrals for service not provided at the school-based wellness center
- Health education and risk prevention counseling

X____ ________________________

Signature of Parent/Guardian **Date:**

HOWARD COUNTY HEALTH DEPARTMENT'S
FACTSHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION

My signature on this form authorizes the release of medical informationfor 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. This information may be protected from disclosure byfederal 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.

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

PARENT/ GUARDIAN CONSENT, AGREEMENT OF FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:
I, the undersigned, voluntarily consent to treatment of my child by the provider contracting with the Howard County Health Department to provide medical services at the School Based Wellness Center (HCHD SBWC). I also voluntarily consent to the use and disclosure of my child's protected health information for treatment, payment and operations and such other purposes that are permitted under the federal Health Insurance Portability and Accountability Act without a written authorization. I accept that I am financially responsible for all services rendered to my child. For those insurance plans for which the health care provider who provided services to my child accepts assignment, I accept personal responsibility for all co-payments, deductibles, and non-covered services, as dictated by my insurance coverage, plus any collection costs for amounts personally owed by me, including attorney fees if necessary. I authorize payment directly to this health care provider for services for which the provider accepts assignment. A copy of this agreement may be used in place of the original. I certify that the information stated on this form is correct.

X____ ______________________________

Signature of Parent/Guardian **Date**

Time Period During Which Release of Information is Authorized:

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

Please make sure you have signed your name and dated the two lines at the top and bottom of this page.

PLEASE PROVIDE A COPY OF THE FRONT AND BACK OF CHILD'S HEALTH INSURANCE CARD.