



P.O. Box 1978  
Salisbury, MD 21802-1978  
Office 410-749-1015 Fax 410-749-1020

Dear Parent/Guardian:

As a student in the Wicomico County School system, your child has access to the Chesapeake Health Care School-Based Health Center. The mission of school-based health is to improve the health of students, increase access to primary health care and decrease time lost from school by providing care within the school setting. We are a convenient source of quality health care staffed by physicians, nurse practitioners, dentists, dental hygienists and licensed behavioral health counselors who work in collaboration with your child's doctor and the school nurse. Your child can receive medical, dental and behavioral health treatment right at school.

**Services:** Chesapeake Health Care can provide treatment for minor health issues/injuries, assistance in managing chronic illnesses, prescriptions, health assessments, routine lab/diagnostic tests, health education, referrals to specialists and sports physicals. Whenever your child is seen by the Health Center staff, a note is sent home that details the visit. Additionally, a report of the visit is shared with your child's primary doctor and a copy maintained at the school-based health center.

**Cost:** Federal and state regulations require all providers, including Chesapeake Health Care, to bill all patients for school-based health center program services. Most health plans, including Medicaid, cover the cost of services at the School-Based Health Center. If your child has health insurance, we will bill the insurance company for health services and follow the billing requirements associated with your plan. As grant funding permits, copays, deductibles, and charges for uninsured/underinsured patients will be waived. Finally, the cost associated with lab services will be billed to your insurance. Bills for these tests will come directly from the lab company. Chesapeake Health Care is unaffiliated with the lab company and has no ability to waive these costs, but has negotiated reduced prices for uninsured patients.

**Enrollment:** All Wicomico County students can enroll in the program. Please complete the attached Enrollment/Consent and Health History forms and return them to the school nurse. Once your child is enrolled in the school-based health center program, they will not need to re-enroll each year. If you have any questions about the program or you would like to schedule an appointment, please call Chesapeake Health Care at 443-397-3844 and speak with staff.





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"ELEMENTARY SCHOOL"

**CONSENT FOR HEALTH SERVICES AND TREATMENT**

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<b>Student's Last Name:</b> _____ <b>Student's First Name:</b> _____ <b>Date of Birth:</b> _____ <b>Student's SSN:</b> _____ <b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <b>Grade:</b> _____ <b>Ethnicity:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other: _____ <b>Student Address:</b> _____ <b>Will CHC or the SBHC be the student's regular:</b> <input type="checkbox"/> Primary care provider <input type="checkbox"/> Dentist <input type="checkbox"/> Behavioral health provider If no, please provide their regular provider below: <b>Name:</b> _____ <b>Specialty:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <b>Phone:</b> _____ <b>Name:</b> _____ <b>Specialty:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <b>Phone:</b> _____ <b>Name:</b> _____ <b>Specialty:</b> <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Behavioral Health <b>Phone:</b> _____	<b>Mother:</b> <b>Last Name:</b> _____ <b>First Name:</b> _____ <b>Father:</b> <b>Last Name:</b> _____ <b>First Name:</b> _____ <b>Legal Guardian, if applicable:</b> <b>Last Name:</b> _____ <b>First Name:</b> _____ <b>Relationship of legal guardian to student:</b> _____  Contact information for primary parent or guardian <b>Name:</b> _____ <b>Cell #:</b> _____ <b>Home #:</b> _____ <b>Work #:</b> _____  Additional emergency contact <b>Name:</b> _____ <b>Cell #:</b> _____ <b>Home #:</b> _____ <b>Work #:</b> _____ <b>Relationship to student:</b> _____

INSURANCE INFORMATION	
Does your child have coverage through your employer or any other type of <b>health</b> insurance, including Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Plan Name:</b> _____ <b>Policy #:</b> _____ <b>Group ID:</b> _____ <b>Medicaid ID# (if applicable):</b> _____	Does your child have coverage through your employer or any other type of <b>dental</b> insurance, including Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Plan Name:</b> _____ <b>Policy #:</b> _____ <b>Group ID:</b> _____ <b>Medicaid ID# (if applicable):</b> _____

**If your child does not have health or dental insurance, would you like to be contacted by an eligibility specialist for assistance with obtaining health or dental insurance?**  Yes  No

**PARENTAL CONSENT FOR SCHOOL-BASED HEALTH CENTER SERVICES**

I consent to Wicomico County Public Schools providing for my child to participate in the School-Based Health Center Program and share information as appropriate. I have read and understand the services listed on the next page (School-Based Health Center Services) and my signature provides consent for my child to receive services provided by the selected School-Based Health Center as long as my child is a student enrolled in Wicomico County Public Schools or until I revoke consent. Note: Under Maryland Law, a minor who is 12 years old or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a physician, psychologist, or clinic. Additionally, a minor (a person under the age of 18) has the same capacity as an adult to consent to medical treatment for drug abuse, alcoholism, and diagnosis and/or treatment for sexually transmitted diseases. If, in the judgement of the attending physician, the life and health of the minor would be affected adversely by delaying treatment to obtain the consent of another individual, a minor may consent to treatment for emergency medical services.

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

**PLEASE BE SURE TO REVIEW BOTH SIDES OF THIS CONSENT FORM**

### SCHOOL-BASED HEALTH CENTER SERVICES

I consent for my child to receive health care services provided by the licensed health professionals at the School-Based Health Center. I understand that the school-based health center will ensure confidentiality in accordance with the law, and that students will be encouraged to involve their parents or guardians in counseling and medical care decisions. School-Based Health Center services may include, but are not limited to:

1. School health services, including: screening for vision, hearing, asthma, obesity, and other medical conditions, first aid, and required and recommended immunizations.
2. Comprehensive physical examination (complete medical examination) including those for school, college, daycare, sports, employment, and new admissions.
3. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes.
4. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications.
5. Mental health services including evaluation, diagnosis, treatment, and referrals.
6. Health education and counseling for the prevention of risk-taking behaviors such as: drug, alcohol, and tobacco use; age appropriate education on abstinence, pregnancy prevention, sexually transmitted infections, and HIV.
7. Dental treatment consisting of examinations, diagnosis & treatment modalities that may include cleaning and sealants.
8. Referrals for services not provided at the school-based health center.
9. Annual health questionnaire/survey.
10. Telehealth services performed via secure communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care.



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**CHC School Based Health Center**

School Year \_\_\_\_\_

NAME \_\_\_\_\_ DOB \_\_\_\_\_ GRADE \_\_\_\_\_

List all medications your child takes daily or on a regular basis:

Medication \_\_\_\_\_ mg \_\_\_\_\_ Directions \_\_\_\_\_

Medication \_\_\_\_\_ mg \_\_\_\_\_ Directions \_\_\_\_\_

Medication \_\_\_\_\_ mg \_\_\_\_\_ Directions \_\_\_\_\_

**Allergies:**

Medication  No  Yes Name of Medication(s) \_\_\_\_\_

Reaction to Medication(s) \_\_\_\_\_

Food  No  Yes Source of Allergy \_\_\_\_\_

Environmental  No  Yes Source of Allergy \_\_\_\_\_

Does your child have a doctor's order for an Epipen?  No  Yes

Does anyone in your home smoke?  No  Yes

**Hospitalizations:**

Reason \_\_\_\_\_ Date \_\_\_\_\_

Reason \_\_\_\_\_ Date \_\_\_\_\_

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? <b>CONDITIONS</b>	CHECK ALL THAT APPLY <b>STUDENT</b>	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? <b>FAMILY MEMBER</b>	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
ADD/ADHD			
Anemia			
Asthma			
Bleeding Disorder			
Cancer			
Mental Health Would you like your child referred to a Mental Health Therapist? Yes / No			
Diabetes			
Drugs / Alcohol / Tobacco Use By Student/Household			
Frequent Colds			
Frequent Ear Infections			
Stomach Problems			
Hearing/Vision Problems/Loss			
Heart Problems			
High Blood Pressure			

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING? <b>CONDITIONS</b>	CHECK ALL THAT APPLY <b>STUDENT</b>	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? <b>FAMILY MEMBER</b>	ADDITIONAL INFORMATION TO HELP US BETTER SERVE YOUR CHILD'S HEALTH NEEDS
High Cholesterol			
Kidney/Bladder Problems			
Lead Poisoning			
Liver Problems (Hepatitis)			
Learning Disability			
Migraines			
Obesity			
Seizure Disorder (Epilepsy)			
Skin Problems (Acne, Eczema, Psoriasis)			
Stroke			
Thyroid Disease			
Tooth Decay			
Tuberculosis			
Wheezing or Trouble Breathing			
Any Other Health Issues:			

Please update your child's insurance information below:

INSURANCE INFORMATION							
Does your child have coverage through your employer or any other type of <b>health</b> insurance, including Medicaid coverage?				Does your child have coverage through your employer or any other type of <b>dental</b> insurance, including Medicaid coverage?			
<input type="checkbox"/> Yes		<input type="checkbox"/> No		<input type="checkbox"/> Yes		<input type="checkbox"/> No	
Plan Name:				Plan Name:			
Policy #:				Policy #:			
Group ID:				Group ID:			
Medicaid ID# (if applicable):				Medicaid ID# (if applicable):			
<b>If your child does not have health or dental insurance, would you like to be contacted by an eligibility specialist for assistance with obtaining health or dental insurance?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No							

This information is for use by the School-Based Health Center and is not part of the school records.

Student's Name \_\_\_\_\_ DOB \_\_\_\_\_

Signature of Parent/Guardian completing this form \_\_\_\_\_

Date \_\_\_\_\_