Chesapeake
HEALTH CARE

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

WORCESTER
COUNTY PUBLIC SCHOOLS

Dear Parent/Guardian:

As a student in Worcester County Public Schools, your child has access to the Chesapeake Health Care School-Based Health Center at Pocomoke High School. 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.

Eligibility: All Worcester County students are eligible to enroll in the program. A student is enrolled once a parent/guardian completes and returns the attached packet.

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 Worcester County students can enroll in the program. Please complete the attached Enrollment/Consent and Health History forms. Return them to your school who will send to the School-Based Health Center at Pocomoke High School. Once your child is enrolled in the school-based health center program, they will not need to re-enroll each year, but WCPS will ask for an annual authorization to refer. If you have any questions about the program, please contact Lauren Williams, Coordinator of School Health Services, at 410-632-5047. If you would like to schedule an appointment, please call Chesapeake Health Care, 410-430-8388 and speak with staff.

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CONSENT FOR HEALTH SERVICES AND TREATMENT

STUDENT INFORMATION

Student's Last Name: _____

Student's First Name: _____

Date of Birth: _____

Student's SSN: _____

Sex: ☐ Male ☐ Female **Grade:** _____

Ethnicity: ☐ White ☐ Black ☐ Hispanic
☐ American Indian ☐ Asian/Pacific Islander
☐ Other: _____

Student Address: _____
_____

Will CHC or the SBHC be the student's regular:
☐ Primary care provider
☐ Dentist
☐ Behavioral health provider

PARENT/GUARDIAN INFORMATION

Mother:
Last Name: _____ First Name: _____

Father:
Last Name: _____ First Name: _____

Legal Guardian, if applicable:
Last Name: _____ First Name: _____
Relationship of legal guardian to student: _____

Contact information for primary parent or guardian
Name: _____ Cell #: _____
Home #: _____ Work #: _____
Email: _____

Additional emergency contact
Name: _____ Cell #: _____
Home #: _____ Work #: _____
Relationship to student: _____
Email: _____

PROVIDER / PHARMACY INFORMATION

If no, please provide their regular provider below:

Name: _____
Specialty: ☐ Medical ☐ Dental ☐ Behavioral Health
Phone: _____
Address: _____
_____

Name: _____
Specialty: ☐ Medical ☐ Dental ☐ Behavioral Health
Phone: _____
Address: _____
_____

Name: _____
Specialty: ☐ Medical ☐ Dental ☐ Behavioral Health
Phone: _____
Address: _____
_____

Pharmacy: _____
Location: _____

INSURANCE INFORMATION

Does your child have coverage through your employer or any other type of ***health*** insurance, including Medicaid coverage?
☐ Yes ☐ No Plan Name: _____
Policy #: _____
Group ID: _____
Medicaid ID# (if applicable): _____

Does your child have coverage through your employer or any other type of ***dental*** insurance, including Medicaid coverage?
☐ Yes ☐ No Plan Name: _____
Policy #: _____
Group ID: _____
Medicaid ID# (if applicable): _____

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 Worcester 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 Worcester 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? **CONDITIONS**	CHECK ALL THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **FAMILY MEMBER**	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? **CONDITIONS**	CHECK ALL THAT APPLY **STUDENT**	HAS A FAMILY MEMBER EVER HAD ANY OF THE FOLLOWING? **FAMILY MEMBER**	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 ***health*** insurance, including Medicaid coverage? ☐ Yes ☐ No Plan Name: _____ Policy #: _____ Group ID: _____ Medicaid ID# (if applicable): _____	Does your child have coverage through your employer or any other type of ***dental*** insurance, including Medicaid coverage? ☐ Yes ☐ No Plan Name: _____ Policy #: _____ Group ID: _____ Medicaid ID# (if applicable): _____
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	

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 _____