

**HOWARD COUNTY HEALTH DEPARTMENT  
SCHOOL-BASED WELLNESS CENTER PROGRAM  
Parental Consent Form**

**PATUXENT VALLEY MIDDLE SCHOOL-BASED WELLNESS CENTER**

STUDENT INFORMATION	PARENT/GUARDIAN INFORMATION
<p><b>Student's Last Name:</b> _____</p> <p><b>Student's First Name:</b> _____</p> <p><b>Date of Birth:</b> _____ / _____ / _____ <i>Month Day Year</i></p> <p><b>Student's Social Security Number:</b> _____</p> <p><b>Sex:</b>   <input type="checkbox"/> Male   <input type="checkbox"/> Female      <b>Grade</b> _____</p> <p><b>Race/ Ethnicity:</b>   <input type="checkbox"/> Hispanic   <input type="checkbox"/> Black   <input type="checkbox"/> White  <input type="checkbox"/> American Indian   <input type="checkbox"/> Asian/Pacific Islander  <input type="checkbox"/> Other _____</p> <p><b>Student's Address:</b> _____  _____  _____ <i>City State Zip Code</i></p> <p><b>Who is the student's regular health provider?</b>  <b>Name:</b> _____  <b>Telephone:</b> _____  <b>Address:</b> _____  _____</p>	<p><b>Mother</b>  Last Name: _____ First Name: _____</p> <p><b>Father</b>  Last Name: _____ First Name: _____</p> <p><b>Legal Guardian, If Applicable</b>  Last Name: _____ First Name: _____  Relationship of legal guardian to student  <input type="checkbox"/> Grandparent   <input type="checkbox"/> Aunt or Uncle   <input type="checkbox"/> Other: _____</p> <p><b>Contact Information for Parent or Guardian</b>  Home Tel: _____ Work Tel: _____  Cell: _____</p> <p><b>Additional Emergency Contact</b>  Name: _____  Relationship to Student: _____  Home Tel: _____ Work Tel: _____  Cell: _____</p>

HEALTH INSURANCE INFORMATION	
<p><b>Does your child have Medical Assistance?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes: Medical Assistance # _____</p> <p><b>Does your child receive health services through a MCO or HMO?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes- Please check the appropriate box below.</p> <p><b>Which Plan?</b>  <input type="checkbox"/> AMERIGROUP   <input type="checkbox"/> Maryland Physicians Care   <input type="checkbox"/> Riverside  <input type="checkbox"/> Diamond   <input type="checkbox"/> Medstar   <input type="checkbox"/> UnitedHealthcare  <input type="checkbox"/> Jai   <input type="checkbox"/> Priority Partners  <input type="checkbox"/> Other: _____</p>	<p><b>Does your child have other health insurance?</b>  <input type="checkbox"/> No   <input type="checkbox"/> Yes: Company's Name: _____</p> <p>Name of Person Listed on Insurance Card:  _____</p> <p>Member's Identification Number:  _____</p> <p><b>If your child does NOT have health insurance, please provide:</b>  <b>Annual Family Income:</b> _____   <b># of Family Members:</b> _____</p>

PARENTAL CONSENT FOR SCHOOL-BASED WELLNESS CENTER SERVICES	
<p>I have read and understand the services listed on the next page (School-Based Wellness Center Services) and <b>my signature provides consent for my child to receive services provided by the HOWARD COUNTY HEALTH DEPARTMENT PATUXENT VALLEY MIDDLE SCHOOL-BASED WELLNESS CENTER.</b></p> <p><b>NOTE: My signature indicates I have received a copy of the Howard County Health Department Notice of Privacy Practices.</b></p> <p>X _____  <b>Signature of Parent/Guardian</b> (or student if 18 years or older or otherwise permitted by law)      <b>Date</b></p>	
<p>I have read and understand the release of health information on page 2 of this form. My signature indicates my consent to release medical information as specified.</p> <p>X _____  <b>Signature of Parent/Guardian</b> (or student if 18 years or older or otherwise permitted by law)      <b>Date</b></p>	

HOWARD COUNTY HEALTH DEPARTMENT  
SCHOOL-BASED WELLNESS CENTER  
Parental Consent Form

PATUXENT VALLEY MIDDLE SCHOOL-BASED WELLNESS CENTER

**SCHOOL-BASED WELLNESS CENTER SERVICES**

I consent for my child to receive health care services provided by the State-licensed health professionals of the Patuxent Valley Middle School-Based Wellness Center . 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 services may include, but are not limited to:

1. Health screening and comprehensive physical examinations (complete medical examination) including those for EPSDT, school and sports
2. Medically prescribed laboratory tests such as for anemia, sickle cell, and diabetes
3. Medical care and treatment, including diagnosis of acute and chronic illness and disease, and dispensing and prescribing of medications
4. Mental health services including evaluation, diagnosis, treatment, and referrals
5. Referrals for service not provided at the school-based wellness center
6. Annual health questionnaire/survey

**HOWARD COUNTY HEALTH DEPARTMENT'S  
FACT SHEET FOR PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION  
HIPAA COMPLIANT PARENTAL CONSENT FOR RELEASE OF HEALTH INFORMATION**

My signature on the reverse side of this form authorizes release of medical information. This information may be protected from disclosure by federal 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.

My questions about this form have been answered. I understand that I do not have to allow release of my child's medical information and that I can change my mind at any time and revoke my authorization by writing to the School-Based Wellness Center. However, after a disclosure has been made, it cannot be revoked retroactively to cover information released prior to the revocation.

I authorize the Howard County Health Department Patuxent Valley Middle School-Based Wellness Center to release specific medical information of the student named on page one (1) to the Howard County Public School System.

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

**My signature on page one (1) of this form also gives my consent to the Howard County Health Department Patuxent Valley Middle 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 or to process insurance claims.**

**Time Period During Which Release of Information is Authorized:**

**From:** Date that form is signed on opposite page

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