



Wellness Center

Delmar Middle/High
School
200 N. Eighth St.
Delmar, DE 19940

O 302-846-0303
F 302-846-0502



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Substance Abuse and Mental Health

Dear Parent/Guardian,

We would like to invite you to enroll your child in the Delmar Middle and Senior High School Wellness Center. We offer an array of health services addressing physical health, mental health, education, and nutritional services for students in grades 5-12 at Delmar Middle and Senior High School. The Wellness Center operates as a partnership between the Delmar School District, the Delaware Division of Public Health, and TidalHealth Nanticoke.

All students who enroll in the Wellness Center are eligible to receive services regardless of their insurance status. Students who do not have health insurance can still be treated and are provided with resources to attempt to obtain insurance. **Students who already have health insurance need to provide a copy of their insurance card annually in order to attempt to bill for services rendered.** No co-pay or payment will ever be collected from you or your child. There will be no cost to you if your insurance denies payment.

Please review and complete the attached forms in their entirety. Unless otherwise stated on the consent form, your child may receive any of the services listed. Please indicate if you do not want your child to receive specific services from the Wellness Center by checking the service(s) you do not want them to receive. Forms can be dropped off to the main office, faxed to 302-846-0502, mailed to the Wellness Center at 200 N. 8th Street, Delmar, DE 19940, or completed online and then scanned or emailed to victoria.cromer@tidalhealth.org.

Please contact the Wellness Center anytime with any questions or concerns at 302-846-0303.

Sincerely,

Cindy Madden, MSN, PNP-BC, FNP-BC
Nurse Practitioner/Wellness Center Coordinator

Staff responsibilities:

1. Center staff will provide each student with considerate, respectful, and appropriate care.
2. Each student will be informed on his/her medical condition(s), or counseling/nutrition plan. Each staff member will encourage students to talk with their family regarding their health concerns.
3. Center staff will not disclose information without student permission. Confidentiality, as required by law, will be maintained in all but the following circumstances.
 1. A student intends to harm self, or others, and there is a clear and immediate danger.
 2. Reporting child abuse of any kind.
 3. Reporting of certain contagious diseases to Division of Public Health.
 4. Response to legal subpoenas.

Student responsibilities:

1. To schedule appointments, students are expected to visit the Center only during study halls, lunch, and before or after school.
2. Students may plan Center appointments during study halls, elective classes, lunch, before or after school, or with teacher permission.
3. Students with appointments must report to class first for attendance, teacher permission, and teacher signature on the pass or agenda.
4. Students are responsible for informing the Center in advance if they need to cancel an appointment.
5. Students are not to congregate in the Center if they do not have appointments, and they will respect the privacy of others and property of the Center.
6. In keeping with standard medical practices, a health history and health risk assessment will be completed by each student using the Center each year. All information provided is confidential and will be used only as a means of assessing health risk behaviors. Students may omit questions on the risk assessment they do not feel comfortable answering.
7. Each student has the responsibility to answer questions honestly and provide all pertinent information concerning his/her health so that the most appropriate care can be planned.
8. Each student has the responsibility to make the health care provider aware if they have been given any information that they do not understand.

Parent/Student Consent For Treatment

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

to receive health services at the Delmar Middle and Senior High School Wellness Center administered by TidalHealth Wellness Center 302-846-0303.

Note: Parents/legal guardians have a right to information about any services provided to minor (less than 18 years) children/teens other than those identified as Reproductive Health/Confidential Services.

Menu of services

1) Physical Health

- **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, pregnancy tests*, dispensing prescription/non-prescription medication and/or providing prescriptions for medication). Services will be coordinated with the student's primary care provider if deemed appropriate.
- **Physical examinations** (i.e., school, sports, employment, or college physicals).
- **Immunizations** in accordance with the Division of Public Health Policy (Immunizations are NOT given to minor students without additional request and consents completed by parents/legal guardians).
- **Nutritional counseling**

2) Counseling

- **Individual or group counseling** including stress management
- **Drug, alcohol and other substance counseling** and referral as deemed appropriate

3) Education

- **Individual and group programs** focusing on healthy life choices

4) Reproductive Health (confidential services)

- **Pregnancy testing**
- **Diagnosis and treatment of sexually transmitted diseases**

*According to Delaware Law (Title 13 §710) students age 12 years and older may request that information pertaining to reproductive health services (pregnancy testing) be kept confidential.

Please circle the number of any of the above services you **WOULD NOT** like your child to receive at the Wellness Center ("declined services").

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
- Complex lab tests
- Hospitalization
- X-rays

PLEASE COMPLETE OTHER SIDE

By my signature below I agree, as the parent or legal guardian of the student named above, that he/she may receive services at the School-Based Wellness Center **(the "Wellness Center")** other than those specifically declined.

Pregnancy testing is considered a confidential service according to state law and is designated "confidential" on the other side of this form. I understand that if I consent to my son/daughter receiving this service at the Wellness Center that:

- I do not have the right to information about confidential services provided to my son/daughter unless my son/daughter gives permission to the Wellness Center to share that information with me.

It is the Wellness Center's philosophy that parents/guardians should be involved in their child's care. Therefore, the Wellness Center strongly encourages communication and involvement among students, parents, and medical providers. I have the right to know about medical care my son/daughter receives for all services that are not considered confidential according to law. I am acknowledging that a copy of the Notice of Privacy Practices is available to myself or my student from the Wellness Center upon request.

School-Based Wellness Centers are funded through state funds and reimbursement from insurance for those students who have insurance. If my son/daughter has insurance I will provide this information to the Wellness Center. I understand that the Wellness Center may bill my insurance for covered services, however the Wellness Center will not charge co-pays or out-of pocket fees to students for services rendered. I understand that my son/daughter can receive services at the Wellness Center regardless of ability to pay.

The Division of Public Health (DPH) retains administrative authority for School-Based Wellness Centers. Designated Wellness 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 and in the US. Information that will be reported includes: sexually transmitted disease, laboratory data, births, deaths, adverse medication reactions, child abuse or neglect, and domestic violence. Students enrolled in School-Based Wellness Centers may be asked to complete the Delaware School Based Health Center Periodic Questionnaire annually to identify health concerns. Other general information may be sent to DPH for statistical tracking, but this information will be de-identified during analysis, which means my son's/daughter's name will be removed. Information about services may be shared with my health insurance company for purposes of quality improvement.

I understand that this consent can 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.

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 more information 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

Address, City, State, Zip

PLEASE COMPLETE OTHER SIDE

Student information									
Please print in ink									
Today's Date:					Primary Care Provider:				
Patient's Last Name:			First:		Middle:			Male	Female
								<input type="checkbox"/>	<input type="checkbox"/>
Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native						Ethnicity (please circle): Hispanic/Latino Arabic Non-Hispanic/Latino/Arabic			
Address:						Home Phone#:			
Patient's Email Address:						Patient's Cell Phone #:			
SSN#:				Birth date:					
School						Grade: 5 6 7 8 9 10 11 12			
Parental/Legal Guardian Information									
Mother's Full Legal Name:						SSN#: (optional)		Birth date:	
Address:						Cell Phone#:			
Employer Name & Address:						Employer Phone#:			
Father's Full Legal Name:						SSN#: (optional)		Birth date:	
Address:						Cell Phone#:			
Employer Name & Address:						Employer Phone#:			
Legal Guardian Name (if not mother or father):						SSN#: (optional)		Birth date:	
Address:						Cell Phone#:			
Employer Name & Address:						Employer Phone#:			
Insurance Information									
Medicaid #:				Name of Medicaid Health Plan:					
Is Medicaid your only insurance? Yes No		If Medicaid is NOT your only insurance, or you do not have Medicaid, please list your information below.							
Primary Insurance Name:						Subscriber Name:			
Group#		Subscriber DOB:		Policy#:					
Patient Relationship to Subscriber		Self	Spouse	Child	Other				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Secondary Insurance Name:						Subscriber Name:			
Group#		Subscriber DOB:		Policy#:					
Patient Relationship to Subscriber		Self	Spouse	Child	Other				
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
In case of an emergency contact:			Relationship to patient:			Phone #:			
Is patient employed? Yes No		Patient's yearly income (optional)							
Patient/Legal Guardian Signature:									Date:

A complete and accurate health history is needed in order for center staff to provide high quality health care. Services will not be provided unless these forms are completed.

Birth Country: United States Mexico France Germany Spain Brazil Haiti
Other _____

Household: Student lives with (circle all that apply): Both Parents Father only Mother only

Lives alone/independent Student is a Parent Extended Family/Relative(s)

Is the home address you provided above: Permanent/Stable Foster Care Shelter

Institution Unstable/Inadequate Host Family (AFS) Other

Will your son/daughter be participating in the State Subsidized School Lunch Program this year? Y N

Is your son/daughter enrolled in Special Education courses? Y N

Has your child seen a health provider in the last year? Y N

If yes, please indicate the # of visits _____ and the reason _____

Has your child been seen in an Emergency Room in the last year? Y N

If yes, please indicate the # of visits _____ and the reason _____

Do you have any worries or questions about your teen's physical or emotional health? _____ No _____ Yes

If so, what are they? _____

Has your teen ever been hospitalized for more than one day and/or had any surgery _____ No _____ Yes

If yes, when? _____ What Hospital? _____

Reason: _____

Do any family members (parents, brother, sister, grandparents, aunts, uncles, etc.) have any of these problems or have they had them in the past? If yes, please indicate which family member(s) next to the appropriate illness.

_____ High blood pressure	_____ Diabetes (sugar)	_____ High cholesterol	_____ Asthma
_____ Heart disease/heart attacks	_____ Thyroid disease	_____ Stroke	_____ Sickle Cell
_____ Mental Illness	_____ Tuberculosis	_____ Kidney disease	
_____ Drug/Alcohol Addiction			
_____ Cancer (please list type) _____			

(Mothers only) If you took any medication other than vitamins or iron while you were pregnant with your son/daughter, please list below:

Please indicate any of the following illnesses or problems that your teen has ever had:

_____ Asthma	_____ Anemia	_____ Arthritis	_____ Thyroid
_____ Rheumatic heart disease	_____ High blood pressure	_____ Sickle Cell Anemia	_____ Kidney disease
_____ Convulsions	_____ Heart murmur	_____ Colitis/stomach problems	_____ Chicken Pox
_____ Ulcers	_____ Epileptic seizures	_____ Measles	_____ Mumps
_____ Fainting spells	_____ Tuberculosis	_____ Diabetes	_____ Hemophilia
_____ Attempted suicide	_____ Head injury	_____ Frequent headaches	_____ Other (please
_____ Sleeping problems	_____ Frequent ear infections	_____ Skin Problems	explain below)

Please list any allergies your son or daughter has _____

Please list any regular medication your son or daughter takes _____

Please indicate your preferred pharmacy _____

Phone _____

If you have any additional questions or concerns, please call the Wellness Center at 302-846-0303

**Home Telehealth Visits
Informed Consent Form**

Student Name: _____

Phone# _____

Provider Name: Delmar Middle and Senior High Wellness Center

1. _____ (name of patient), consents to receive clinical services by **Home Telehealth Visit**. A telehealth visit may include the use of telephone, interactive audio, video, audio visual or other telecommunications, or electronic technology by a licensed healthcare provider to deliver clinical services within the scope of practice of the healthcare provider at a location other than the location of the patient.
2. I understand that the laws that protect the privacy and confidentiality of my personal information also apply to telehealth. Nevertheless, there are privacy and confidentiality risks inherent in technology-based services, including telehealth.
3. I understand that as with any technology, telehealth has its limitations. There is no guarantee; therefore, that telehealth will eliminate the need for me to see a healthcare practitioner in person.
4. This consent will serve as an addendum to the consent currently on file in the Wellness Center.

Parent/Legal Guardian/Patient

Date

Student Signature

Date