The Wellness Center at
Delmar Middle and Senior High School

200 North Eighth Street, Delmar, DE 19940
302-846-0303

Dear Parent/Legal 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 dealing with physical health, mental health, education, nutrition and limited lab screenings. The Wellness Center operates as a partnership between the school, Delaware Division of Public Health and Nanticoke Health Services.

Due to changes mandated by the Division of Public Health (who fund the centers) insurances/Medicaid will now be billed for services rendered. Therefore, if you have private insurance or Medicaid it is now imperative that we have accurate, current insurance information. Please provide a front and back copy of your child's current insurance card. Please notify the Wellness Center and provide updated information if your child's insurance changes.

All students who enroll in the Wellness Center will be eligible to receive services regardless of their insurance status. The Wellness Center will not charge co-pays or out of pocket fees for services.

Of course, as before, the parent/legal guardian may choose from a menu of services and can choose to enroll their student or not. Parents may receive documentation from insurance providers when students receive services through the center.

Delmar Middle-Senior High School students in grades **6-12** may be enrolled in the Wellness Center by their parent or legal guardian.

If you have any questions or concerns please feel free to call us at 302-846-0303.

Sincerely,

Cindy Madden, RN, MSN, ARNP
Wellness Center Coordinator/NP

THE WELLNESS CENTER AT DELMAR MIDDLE AND SENIOR HIGH SCHOOL
STAFF AND STUDENT RESPONSIBILITIES

STAFF RESPONSIBILITIES:

1. Center staff will provide each student with considerate, respectful, and appropriate care.

2. Each student will be informed of his/her medical condition(s), or counseling/nutritional 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:
    a. A student intends to harm self or others and there is a clear and immediate danger.
    b. Reporting child abuse of any kind.
    c. Reporting of certain contagious diseases to Division of Public Health.
    d. Response to legal subpoenas.

4. When possible, staff will schedule students during study halls. When schedules do not permit scheduling during study hall, appointments will be scheduled during class times but permission to leave class is at the discretion of the teacher.

STUDENT RESPONSIBILITIES:

1. To make appointments, students are expected to visit the Center before or after school, during lunch with pass, or with a signed consent from their teacher.

2. Students with appointments must always report to class first for attendance, teacher permission, and the teacher's signature on the pass.

3. Students may not come to the Wellness Center when a test is being given in their class; they need to reschedule any such appointment.

4. Students are responsible for informing the Center in advance if they need to cancel an appointment.

5. It is expected that students do not congregate in the Center if they do not have appointments, and that they respect the privacy of others and the property of the Center.

6. In keeping with standard medical practices, each student using the Center will complete a health history and health risk assessment. All information provided is confidential and will be used only as a means of assessing health risk behaviors.

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.

DELMAR SCHOOL-BASED WELLNESS CENTER
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/Senior High School Wellness Center administered by Nanticoke Health Services.
Wellness Center Telephone Number: 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, medically indicated 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. sports/employment/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 if deemed appropriate

3. EDUCATION
   Individual and group programs focusing on healthy life choices

4. REPRODUCTIVE HEALTH (CONFIDENTIAL SERVICES)
   Diagnosis and treatment of sexually transmitted disease*

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

Please circle the number of any of the above service groups 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 and diagnosis and treatment of sexually transmitted disease are considered confidential services 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 these services at the Wellness Center that:

- I do not have the right to access 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.

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

Delmar Wellness Center
Student Registration Form

Student Information			**Please Print In Ink**
Today's Date:	Primary Care Provider:		
Patient's Last Name: First: Middle:		Male ☐	Female ☐
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#:	
SSN#:	Birth date:		
School		Grade: 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 ☐
Secondary Insurance Name:		Subscriber Name:		
Group#	Subscriber DOB:	Policy#:		
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
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 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	
___ Sleeping problems	___ Frequent ear infections	___ Skin Problems	

___Other (please explain)____

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.