TidalHealth™

Wellness Center

Seaford High School
399 North Market St.
Seaford, DE 19973

O 302-628-2180
F 302-629-0886

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 Seaford High School Wellness Center. We offer an array of health services addressing physical health, mental health, education, and nutritional services for students in grades 9-12 at Seaford High School. The Wellness Center operates as a partnership between the Seaford School District, the Delaware Division of Public Health, and TidalHealth.

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 302-629-0886, mailed to the Wellness Center at 399 North Market St., Seaford, DE 19973, or completed online and then scanned or emailed to robin.hayes@tidalhealth.org.

Please contact the Wellness Center anytime with any questions or concerns at 302-628-2180.

Sincerely,

Tina Torres, MSN, APRN, 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 Seaford High School Wellness Center administered by TidalHealth Wellness Center 302-628-2180.

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)

***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.**

- **Condoms**
- **Oral contraception to prevent pregnancy**
- **Pregnancy testing**
- **Diagnosis and treatment of sexually transmitted diseases**
- **DEPO-PROVERA injectable birth control option (Depo-Provera is a shot given to females every 3 months to prevent pregnancy.)**
- **NuvaRing (NuvaRing is a vaginal ring containing combination hormone medication and is used to prevent pregnancy.)***

For more information visit: http://www.dhss.delaware.gov/dph/chca/dphcontraceptives.html

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

*as available from pharmacy

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

Home Telehealth Visits
Informed Consent Form

Student Name: _____
Phone#_____
Provider Name: _____Seaford 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

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#:**	
Patient's Email Address:		**Patient's Cell Phone #:**	
SSN#:	**Birth date:**		
School		**Grade**: 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 <u>will not</u> 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
_____ Heart disease/heart attacks
_____ Mental Illness
_____Drug/Alcohol Addiction
_____ Cancer (please list type)_____
_____ Diabetes (sugar)
_____ Thyroid disease
_____ Tuberculosis
____ High cholesterol
____ Stroke
____ Kidney disease
_____Asthma
_____Sickle Cell

(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
____ Rheumatic heart disease
____ Convulsions
____ Ulcers
____ Fainting spells
____ Attempted suicide
____ Sleeping problems
____ Anemia
____ High blood pressure
____ Heart murmur
____ Epileptic seizures
____ Tuberculosis
____ Head injury
____ Frequent ear infections
____ Arthritis
____ Sickle Cell Anemia
____ Colitis/stomach problems
____ Measles
____ Diabetes
____ Frequent headaches
____ Skin Problems
____Thyroid
____ Kidney disease
____ Chicken Pox
____ Mumps
____ Hemophilia
____Other (please 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 302-628-2180