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,

The Seaford High School Wellness Center is pleased to offer Seaford Middle School students the opportunity to have sports physicals completed at the Seaford High School Wellness Center. 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 provided with resources to attempt to obtain insurance. Students who are without insurance will be seen without charge to parent/student, parent/guardian must note “uninsured” on the registration form. **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 note, students will be seen by appointment only during regularly scheduled Seaford High School Wellness Center hours. Students will be escorted from the Middle School to the High School Wellness Center and back by Middle School staff for appointments during school hours. Appointments will occur during normal school hours with some limited summer hours available. Transportation will not be provided during summer hours or after school hours, and will be the responsibility of the parent/guardian.

If you are interested in having your Middle School student come to the Seaford High School Wellness Center for a sports physical, you will need to:

- **Complete the Middle School Wellness Center registration and consent forms**
- **Provide a copy of the student’s current insurance or Medicaid cards**
- **Complete the DIAA sports physical form**
- **Turn in all forms to Middle School front office who will coordinate appointment time with the Wellness Center**

Please review and complete the attached forms in their entirety.

Please contact the Wellness Center anytime with any questions or concerns.

Sincerely,
Tina Torres, MSN, APRN, FNP-BC
Nurse Practitioner/Wellness Center Coordinator

Parent/Student Consent For Treatment

I, _____, give my consent for_____
(Parent/Legal Guardian of Student) **(Name of Student)**
to receive sports physicals at the Seaford High School Wellness Center administered by TidalHealth Wellness Center 302-628-2180.

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

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 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**: 6 7 8	

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