TidalHealth™

Wellness Center

Laurel High School
1133 S. Central Ave.
Laurel, DE 19956

O 302-875-6164
F 302-875-6166

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

All students who enroll in the TidalHealth 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 TidalHealth 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 302-875-6166, mailed to the TidalHealth Wellness Center at 1133 S. Central Ave., Laurel, DE 19956, or completed online and then scanned or emailed to Brenda.i.king@tidalhealth.org.

Please contact the TidalHealth Wellness Center anytime with any questions or concerns at 302-875-6164.

Sincerely,

Brenda King, DNP, APRN, CNP
Nurse Practitioner/TidalHealth 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.

2. 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 TidalHealth Wellness Center only during study halls, lunch, and before or after school.

2. Students may plan TidalHealth Wellness 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 TidalHealth Wellness Center in advance if they need to cancel an appointment.

5. Students are not to congregate in the TidalHealth Wellness Center if they do not have appointments, and they will respect the privacy of others and property of the TidalHealth Wellness Center.

6. In keeping with standard medical practices, a health history and health risk assessment will be completed by each student using the TidalHealth Wellness 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 licensed practitioner aware if they have been given any information that they do not understand.

TidalHealth 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 Laurel High School administered by TidalHealth Wellness Center 302-875-6164.

Note: Parents/legal guardians have a right to information about any services provided to minor (less than 18 years) children/teens except those identified as reproductive health/confidential services.

Menu of services

Please indicate the services you **would not** like your child to receive at the TidalHealth Wellness Center ("declined 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 practitioner 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)

<u>*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.</u>

- 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.) *as available from pharmacy

For more information visit <u>https://dhss.delaware.gov/</u>

The TidalHealth 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

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 "TidalHealth 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 TidalHealth 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 TidalHealth Wellness Center to share that information with me.

Privacy and reporting:
It is the TidalHealth Wellness Center's philosophy that parents/guardians should be involved in their child's care. Therefore, the TidalHealth Wellness Center strongly encourages communication and involvement among students, parents/legal guardians, and licensed healthcare practitioners. Parents/legal guardians have the right to know about medical care their child receives for all services that are not considered confidential according to Delaware law.

_____(initials) I acknowledge that a copy of the Notice of Privacy Practices is available from the TidalHealth Wellness Center upon request or you can visit tidalhealth.org/privacy-practice.

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 TidalHealth Wellness Center. I understand that my insurance may be billed for covered services, however the TidalHealth 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 TidalHealth 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 child’s name and other identifiers will be removed. Information about services may be shared with my health insurance company for purposes of quality improvement.

_____ (initials) I understand that The TidalHealth Wellness Center utilizes a third party company to receive protected health information from students’ medical records to provide data to the School-Based Health Alliance (“SBHA”) and the Delaware School-Based Health Alliance (“DSBHA”) for the purpose of the analysis of school-based healthcare in Delaware and for the purpose of quality improvement and the advocating of School Based Health Centers (“SBHCs”).

I understand that this consent is valid for the duration of time my child attends this school.

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 TidalHealth 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 TidalHealth 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

Telehealth Home Visits
Informed Consent Form

Student name: _____

Phone number: _____

Provider name: TidalHealth Wellness Center at Laurel High School

1. _____ (name of patient), consent 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 practitioner to deliver clinical services within the scope of practice of the licensed practitioner 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 that telehealth will eliminate the need for me to see the licensed practitioner in person.

4. This consent will serve as an addendum to the consent currently on file in the TidalHealth Wellness Center.

_____

Parent/legal guardian/patient Date

_____

Student signature Date

Student Registration Form

Student information
Please print in ink

Today's date:		Primary Care Practitioner:		
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 **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 licensed practitioner i 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? Y N

If so, what are they? _____

_____

Has your teen ever been hospitalized for more than one day and/or had any surgery? Y N

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	___ 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 explain below)
___ Sleeping problems	___ Frequent ear infections	___ Skin problems	

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 TidalHealth Wellness Center at 302-875-6164.