DEPARTMENT OF HEALTH AND HUMAN SERVICES
School Based Health and Wellness Centers

Enrollment Form

SBHWC Location _____ **Student ID #** _____

Student's Name_____ **Home School**_____ **Grade**_____

Date of Birth (mm/dd/yy) _____ **Gender** _____ **Race/Ethnicity**_____

Address _____ **Home Phone**_____

City_____ **State** _____ **Zip Code**_____ **Student Phone**_____

Country of Birth _____ **Primary Language spoken at home** _____

Parent/Guardian _____ **Phone #** _____

Parent/Guardian Email _____

Emergency Contact _____ **Phone #** _____

Emergency Contact Relationship to Student _____

☐ **Check Here to Opt Out of Text Reminders for Appointments**

I give permission for my child, _____, to enroll in the School Based Health/Wellness Center (SBHWC). I consent to his/her receiving services which may include complete physical examinations, immunizations, treatment for chronic and acute health problems, health screenings, limited laboratory and diagnostic tests, administration/prescribing of medications, health education, case management and /or referrals to mental health and social services. I give permission for SBHWC health and mental health professionals and School Health Services staff to share information or records as needed to provide appropriate services to my child through the SBHWC and support my child's success in school.

I understand:

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the School Based Health/Wellness Center (SBHWC).
- All SBHWC records are confidential and only the SBHWC staff and providers will have access to a child's SBHWC records and information, unless the parent/guardian gives written consent, or the minor patient gives written consent, in the event the minor is receiving treatment for which the minor has the authority to consent.
- At this time, Maryland law does not require parental consent or notification for the following services provided by the SBHWC: treatment or advice about drug abuse, alcoholism, sexually transmitted infections, pregnancy or contraception to minors under 18 years of age, and mental health services to minors age 16 years or older.
- Services at the SBHWC will be provided by staff employed by or contractors with Montgomery County Department of Health and Human Services.
- If my child has health insurance through an insurance company that participates with Montgomery County, the insurer will be billed for services given in the SBHWC and the insurer may be provided required information about the child's health status or other information necessary to process insurance claims.
- If my child does not have health insurance, I will indicate on my enrollment form and I will be contacted by SBHWC staff to assist in applying for Maryland Children's Health Program (HealthChoice) or Care for Kids coverage.
- I am authorizing any payment of medical benefits for services rendered in the SBHWC to be directed to Montgomery County.
- **All enrolled children will be seen regardless of their insurance status and I will not receive a bill for services provided in the SBHWC.**

I understand the description of services and policies of the SBHWC as stated above and give permission for my child to enroll and receive services in the SBHWC. I understand that this permission can be withdrawn at any time by submitting notice in writing.

Signature of Parent/Legal Guardian_____ **Date**_____

Print Name _____ **Relationship to Student** _____

PLEASE RETURN FORMS TO THE HEALTH ROOM

Date Form Completed _____ **SBHWC Location** _____

Montgomery County Department of Health and Human Services
School Based Health and Wellness Center

Health Insurance Information

Student's Name _____ _____ _____
(last) *(first)* *(middle)*

SSN# _____ Date of Birth (mm/dd/yy) _____

Pediatrician _____ Phone # _____ Fax # _____

Pediatrician Address _____

Date of Last Physical Exam _____ Pediatrician Email _____

I authorize notification of my child's Pediatrician of SBHWC enrollment/visits Yes ◯ No ◯

Please complete the information below. Please provide a copy of your insurance card. Your insurance company may be billed.

Parent/Guardian Name: _____ Date of Birth (mm/dd/yy) _____

Parent/Guardian Name: _____ Date of Birth (mm/dd/yy) _____

Does your child have health insurance? Yes ◯ No ◯

If yes, please check and complete one of the following:

☐ My Child is enrolled in the Care For Kids Program PULS # _____

☐ My Child has Medical Assistance (HealthChoice or Kaiser) *Complete below and attach a copy of card, if available*

Child's Medical Assistance # (11-digits) _____

If Kaiser, Medical Record Number _____

Child's Managed Care Organization _____

☐ My Child has private health insurance *Complete below and attach a copy of health insurance card, if available*

Name of Policy Holder _____

Relationship to Child _____

Social Security or ID Number of Policy Holder _____

Policy Holder's Place of Employment _____

Name of Insurance Company _____

Insurance Billing Address _____

_____

All children will be seen regardless of their insurance status and will not receive a bill for services provided at the SBHWCs

PLEASE RETURN FORMS TO THE HEALTH ROOM

SCHOOL BASED HEALTH and WELLNESS CENTER

Consent to Administer Over the Counter Medications to Enrolled Students

The medications listed below are stocked at the School Based Health and Wellness Centers. If your child is **enrolled** for services, he/she/they may be given one of these medications, if in the judgment of the school nurse or nurse practitioner they might be helpful. You will be notified by telephone or by note, if and when your child is given of these medications.

To give permission for your child to take any of these medications, please check **YES** below. If you do not want your child to receive one or more of these medications, check **NO.**

ACETAMINOPHEN {Tylenol} ◯ YES ◯ NO

-For fever greater than 100.4˚F and/or discomfort/pain.

IBUPROFEN ({Advil}, {Motrin}) ◯ YES ◯ NO

-For fever greater than 100.4˚F and/or discomfort/pain.

ANTIHISTAMINE (Loratidine {Claritin}) ◯ YES ◯ NO

-For itching and/or cold symptoms.

ANTIHISTAMINE (diphenhydramine hydrochloride {Benadryl}) ◯ YES ◯ NO

-For allergy symptoms and/or allergic reaction.

Child's Name _____ DOB _____

Parent/Guardian Signature_____Date_____

PLEASE RETURN FORMS TO THE HEALTH ROOM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
School Based Health and Wellness Centers

Student Health History

Patient Name:	Date of Birth:	Gender:
Form Completed By:	Relationship to patient (i.e. parent):	Today's Date:

Family Medical History (parents, grandparents, brothers/sisters)			**Patient Medical History**		
Has anyone in your family had:	**Yes**	**No**	**Has your child ever had:**	**Yes**	**No**
Respiratory (Lung) problems such as asthma:	☐	☐	Allergies:	☐	☐
Neurologic (Brain) problems such as seizures or stroke:	☐	☐	Asthma or other lung problems including tuberculosis:	☐	☐
Cardiac (Heart) problems such as heart disease, high blood pressure, high cholesterol, heart attack:	☐	☐	Vision or hearing problems:	☐	☐
			Heart problems:	☐	☐
			Seizures:	☐	☐
Endocrine problems such as Diabetes or thyroid disease:	☐	☐	Diabetes:	☐	☐
			Learning problems:	☐	☐
Blood disorders such as sickle cell anemia:	☐	☐	Bleeding disorders:	☐	☐
			Behavioral problems:	☐	☐
Mental Health problems:	☐	☐	Mental health problems:	☐	☐
Learning differences:	☐	☐	Bone or joint injuries:	☐	☐
Other:	☐	☐	Skin problems such as eczema:	☐	☐
			Has your child ever been hospitalized?	☐	☐
			Has your child ever had surgery?	☐	☐
			Has your child ever needed to see a specialty doctor?	☐	☐
			Did your child have any problems at birth?	☐	☐
			Does your child take any medications or over the counter supplements:	☐	☐
			Other:	☐	☐

If you answered YES to any of these questions, please explain WHO and give any additional pertinent details:

If you answered YES to any of these questions, please explain and give any additional pertinent details:

Montgomery County Department of Health and Human Services

Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?

We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?

Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice.*

Contact Information:

If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 3050. Additional contact information is provided at the end of the *Notice.*

Acknowledgement of receipt of the complete *Notice*:

_____ _____

Client or Authorized Representative (Sign your name) Date

_____

Print your name

_____ _____

Signature of DHHS representative Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: _____