BALTIMORE COUNTY PUBLIC SCHOOLS
TOWSON, MARYLAND 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND 21212

PARENTAL CONSENT FORM FOR SECONDARY WELLNESS CENTER

I am granting permission for my child to enroll in the Comprehensive School-Based Wellness Center and consent to his/her receiving health related services which can include physical examinations, health screenings, limited diagnostic tests, education, counseling, referrals, and administration of necessary medications. I understand the school nurse is responsible for follow-up care and will have access to the Wellness Center records. You have my permission to release any Wellness Center information to any health or mental health professional providing services to my child through the Wellness Center. You have my permission to release any educational information to any health or mental health professional who needs this information to care for my child through the Wellness Center.

- **My signature on this consent certifies that I have received Baltimore County Department of Health Notice of Privacy Practices.**
- **I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, drug abuse, mental health (16 years of age or older), and contraception.**
- I understand that I am responsible for medical care if follow-up outside the school-based center is recommended.
- I authorize the release of any medical or other information necessary to process insurance claims, if applicable.
- I authorize payment of medical benefits to Baltimore County for services rendered at the Wellness Center.
- I agree that if I receive payment from my insurance company for services rendered at a Wellness Center, I will endorse the check and forward it to the Wellness Center.
- I understand that if my child is registered with a Managed Care Organization (MCO) through Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school health center.
- I understand that my child's immunization record will be entered on the Maryland registry, ImmuNet, if vaccines are given.

Print Child's Name_____ Birth Date_____ Grade_____
Address_____ Zip_____
Child's Social Security Number_____ ☐ Male ☐Female
Child's Health Care Provider_____ Telephone_____
Print Name of Parent/Guardian_____ Mother's Maiden Name _____ ___
Relationship to Student_____ Telephone (H)_____(W)_____
Signature of Student_____ Date_____

Signature of Parent/Legal Guardian_____ Date_____

IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:

Child's Medical Assistance Number: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____
Child receives MA services through an MCO? _____YES _____NO
If YES, name of MCO_____

IF YOUR CHILD'S HEALTH CARE IS COVERED BY PRIVATE INSURANCE, PLEASE COPY <u>ALL</u> THE FOLLOWING INFORMATION <u>DIRECTLY</u> FROM YOUR INSURANCE CARD:

1. Insurance Company's Name & Address_____
   _____ City_____ Zip_____
   Insurance Company's CLAIMS (Billing) Address (if different from above)_____
   _____ City_____ Zip_____
   Insurance Company's Phone Number_____
2. Name of Individual listed on Insurance Card_____
   Policy Number of Insured Listed on Card _____
   Group Number Listed on Health Insurance Card_____
3. List the name of the Policy Holder (person whose name the insurance policy is under)_____
   Social Security Number of Policy Holder_____
   Place of Employment of Policy Holder_____
   _____ Work Phone Number (___)_____
   Relationship of Policy Holder to Child_____
   Home Address of Policy Holder_____

IF YOUR CHILD HAS <u>NO</u> HEALTH CARE COVERAGE THROUGH AN HMO, MEDICAL ASSISTANCE, OR PRIVATE INSURANCE, PLEASE INDICATE BY PLACING A (√) IN THIS SPACE. ( ) AND COMPLETE BELOW.

Please indicate Annual Income: _____ **Number of Family Members:** _____

If you need help with Medical Assistance, please call the Office of Third Party Billing: 443-809-4130

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE!