

Wilmington Health Access for Teens
a program of Coastal Horizons Center, Inc.

Ashley Wellness Center
Parent/Guardian Consent Form
School Year 2016-17



Please sign and return this form to the main office at Ashley High School to
Attn: Wellness Center or fax it to (910) 791-4166.

Dear Parent/Guardian:

All students seeking healthcare at the Ashley Wellness Center must have written, parental authorization to participate and receive needed services or as may be required by N.C. law or ethical guidelines for medical professions. If you have any questions, please visit our website (www.whatswhat.org) or call us at (910) 452-6320.

I, _____ (please print), hereby grant permission for my child,

_____ (please print), to participate in the activities and
services offered by the Ashley Wellness Center in partnership with Wilmington Health Access for Teens (WHAT), a
program of Coastal Horizons Center, Inc.

I authorize **ALL** services and activities offered by the Ashley Wellness Center. (**circle one**) Yes No
ONLY if you selected **NO**, please circle **Yes** or **No** for each listed service:

1. Conducting of interviews, tests, and questionnaires for student or project evaluation purposes. Yes No
2. Release of confidential information (financial, public assistance, medical, and all educational records) to qualified professional staff of the Ashley Wellness Center as needed. Also, from the Ashley Wellness Center to other qualified professionals for purposes of health care, insurance/Medicaid claims, or to access needed services for my child. Yes No
3. Referrals to other agencies for specific services (e.g. health, public assistance, counseling, psychological testing, etc.). Yes No
4. Authorization for my child to be transported on trips for appointments, meetings and other activities. Yes No
5. If my child is currently a Medicaid recipient, authorization for my child to have transportation arranged or provided by the New Hanover County Department of Social Services for medical appointments or related services. Yes No
6. Participation in services specified in my child's individualized student/family plan, such as counseling, health instruction and cultural enrichment. Yes No
7. Health care related activities and services that could include:
 - a. Physical health appraisal including acute care, sports injury, preventive health care Yes No
 - b. Laboratory services including screening Yes No
 - c. Appropriate health education, health promotion, and injury prevention Yes No
 - d. Immunizations Yes No
 - e. Nutrition and physical fitness counseling Yes No
 - f. Dental screening and referrals Yes No
 - g. Participation in management of chronic illness such as asthma, diabetes Yes No
 - h. Mental health assessment, counseling, and referral ranging from emergencies to follow-up care including depression, self-destructive and violent behavior Yes No
 - i. Substance abuse prevention, assessment, counseling, and referral for treatment Yes No
 - j. Adolescent growth, reproductive, and development information, services, and counseling Yes No
 - k. Education, prevention, and treatment of sexually transmitted disease, including HIV and Hepatitis B Yes No
 - l. Social worker services, in cooperation with school staff, including referral for and development of community resources Yes No

