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

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

Please sign and return this form to the main office at Hoggard High School to Attn: Wellness Center or fax it to (910) 790-9455.

Dear Parent/Guardian:

All students seeking healthcare at the Hoggard 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) 790-9949.

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

____(please print), to participate in the activities and services offered by the Hoggard 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 Hoggard 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 Hoggard Wellness Center as needed. Also, from the Hoggard 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

m. Consultation and referral for school performance problems including ADD/ADHD, learning disorders, and other issues that prevent your child from effectively adapting to life's demands Yes No

8. Publicity activities such as interviews, photos and videos. Yes No

By signing:

- I understand that there are charges/fees for medical /counseling visits to the Hoggard Wellness Center as in any visit to physician's office/clinic. I also understand that some of these services may not be completely covered under insurance/Medicaid and that I am responsible, within my financial ability, for any unpaid balance.
- I understand that the Hoggard Wellness Center staff encourages all students to share information with their parents/guardians, and that I will be notified of any life threatening conditions.
- I understand that I may revoke this consent at any time, except to the extent services have already been rendered. Otherwise, this consent shall continue to remain valid from the date signed until my child's enrollment at Hoggard High School ends.
- I understand that I will supply the Hoggard Wellness Center with a copy of my child's immunization record. If I am not able to supply this record, the Wellness Center will attempt to determine my child's immunization status and the following immunizations will be administered according to the recommendations of the American Academy of Pediatrics: Menactra (for Meningitis), Influenza Vaccine, Hepatitis A and B Series.
  NOTE: TDAP and MMR are required for school enrollment.

Student's Name (please print): ____
(First) (Middle Initial) (Last)

Student's date of birth (month/day/year): __________________ Student's Social Security #:__________________________

Sex: ____M _____F Age:______ Grade: ______ Race/Ethnicity:
_____White/Non-Hispanic _____Black/African American _____American Indian/Native Alaskan
_____Hispanic _____ Asian _____Native Hawaiian/Other Pacific Islander

Has your child had Chicken Pox or been vaccinated? YES______ NO______
If yes, please provide approximate date of disease __________________ or dates of vaccination____________________

Student's legal guardian/s: ____ Mother _____Father ____ Both parents
____ Other (please specify):____

Parent/Legal Guardian Name:__________________________________Relationship to Student: ___________________

Address: ____ City, State, Zip:_____________________________________

Home Phone: ______________________ Work Phone: _____________________ Cell Phone: _______________________

Email:_____________________________ Date of Birth:_______________ Social Security Number:____________________

Parent/Legal Guardian Name:__________________________________Relationship to Student: ___________________

Address: ____ City, State, Zip:_____________________________________

Home Phone: ______________________ Work Phone: _____________________ Cell Phone: _______________________

Email:_____________________________ Date of Birth:_______________ Social Security Number:____________________

Student Signature: ____ **Date:** _______________________

Parent/Legal Guardian Signature: ____ **Date:**_______________________

Coastal Horizons Center, Inc., and its school wellness centers do not discriminate against any person on the basis of sex, race, ethnicity, national origin, sexual orientation, religion or disability.