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

Ashley Wellness Center
Parent/Guardian Consent Form
School Year 2017-18

Coastal Horizons
WILMINGTON HEALTH ACCESS FOR TEENS

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
    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 Ashley 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 Ashley 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 Ashley High School ends.
- I understand that I will supply the Ashley 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: <u>TDAP and MMR are required for school enrollment.</u>

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:**_____