

Wilmington Health Access for Teens
a program of Coastal Horizons Center, Inc.
Laney Wellness Center
Parent/Guardian Consent Form
School Year 2017-18



Please sign and return this form to the main office at Laney High School to Attn: Wellness Center or fax it to (910) 392-0505.

Dear Parent/Guardian:

All students seeking healthcare at the Laney 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) 452-9503.

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

_____ (please print), to participate in the activities and services offered by the Laney 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 Laney 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 Laney Wellness Center as needed. Also, from the Laney 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 | Yes | No |

disorders, and other issues that prevent your child from effectively adapting to life's demands

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 Laney 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 Laney 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 Laney High School ends.
- I understand that I will supply the Laney 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:** _____