New Hanover County School Wellness Centers
Parent/Guardian Consent Form

Please sign and return this form to your school's main office or the WHAT Wellness Center office.

Dear Parent/Guardian:

All students seeking healthcare at the 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 Wellness Center in partnership with Wilmington Health Access for Teens (WHAT), a program of Coastal Horizons Center, Inc. Consent is valid for the length of student's enrollment in a New Hanover County High School.

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

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 Coastal Horizons Wellness Center as needed. Also, from the School Based Health Center/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. Participation in services specified in my child's individualized student/family plan, such as counseling, health instruction and cultural enrichment. Yes No

5. Physical health care related activities and services that can include immunizations, telehealth services, well child checks, sports physicals, laboratory services, appropriate health education/promotion, etc. Yes No

   - I understand that I will supply the 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. Yes No

6. Mental/Behavioral health care related activities and services that can include assessment, treatment planning, counseling, referrals and follow up care. Yes No

By signing:

- I understand that there are charges/fees for medical /counseling visits to 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 and that I am responsible, within my financial ability, for any unpaid balance.
- I understand that the 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 any New Hanover County High School ends.

Student's Name (please print): ____

(First) (Middle Initial) (Last)

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

Student is enrolled at (Circle one): Ashley Hoggard Laney New Hanover

Sex assigned at Birth: ____M _____F Preferred Pronouns: _________ 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____________________

Parent/Legal Guardian Name:____________________________________Relationships to Student: ________________

Parent/Legal Guardian Name:____________________________________Relationships to Student: ________________

Address: ____ City, State, Zip:_____________________________________

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

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

Does your child currently have health insurance (including Medicaid)?
Insurance Company's Name:
Person's name on the insurance card:
Insurance company's telephone #:
Insurance policy #:
Insurance ID #:
Policy Holder's (Parent/Guarantor) Date of Birth: Relationship to Student:
Doctor's name, if any, listed on the insurance card:

Please provide WHAT of Coastal Horizons with a copy (front and back) of your child's insurance or Medicaid card along with this form, or provide WHAT with the card and a copy will be made for you. Thank you!

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, gender identity, religion or disability.