Sussex Central High School
Wellness Center
Patient Registration Form

Patient Information Please Print

Today's Date:	Primary Care Provider:			
Patient's Last Name: First: Middle:			Male ☐	Female ☐
Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native			Ethnicity (please circle): Hispanic/Latino Arabic Non-Hispanic/Latino/Arabic	
Address:			Phone#:	
SSN#:	Birth date:			

Parental/Legal Guardian Information

Mother's Full Legal Name:	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	
Father's Full Legal Name:	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	
Legal Guardian Name (if not mother or father):	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	

Insurance Information

Medicaid #:	Name of Medicaid Health Plan:			
Is Medicaid your only insurance? Yes No	If Medicaid is NOT your only insurance, or you do not have Medicaid, please list your information below.			
Primary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
Secondary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
In case of an emergency contact:	Relationship to patient:		Phone #:	
Is patient employed? Yes No	Patient's yearly income	Household yearly income:	# of family members in household:	
Parent/Legal Guardian Signature:			Date:	

SUSSEX CENTRAL HIGH SCHOOL-BASED WELLNESS CENTER
PARENT/STUDENT CONSENT FOR TREATMENT

I, _____, give my consent for_____
(Parent/Legal Guardian of Student) **(Name of Student)**

to receive health services at the Sussex Central High School Wellness Center administered by: Beebe Medical Center Telephone Number (302) 934-5962.

MENU OF SERVICES

PHYSICAL HEALTH

- Assessment, diagnosis and treatment of minor illness and injury with referral for treatment of chronic illness and serious injury (May include a urinalysis, throat culture, limited blood tests, dispensing non-prescription medication and/or providing prescription medication)
- Physical examinations, including sports/employment physicals
- Immunizations in accordance with the Division of Public Health
- Coordinating services with student's Primary Health Care Provider
- Referral of a student who does not have a primary care provider to a physician
- Nutrition services and referrals

COUNSELING

- Individual counseling
- Group counseling
- Family counseling
- Drug, alcohol and other substance abuse counseling and referrals
- Referrals for long-term counseling or other evaluations

EDUCATION

- Individual and group programs focusing on healthy life choices

CONFIDENTIAL SERVICES

- Pregnancy testing
- Diagnosis and treatment of Sexually Transmitted Infections
- HIV counseling and testing
- Contraceptives

THE WELLNESS CENTER DOES *NOT* PROVIDE THE FOLLOWING SERVICES

- Treatment or testing of complex medical or psychiatric conditions
- Ongoing primary treatment of chronic medical conditions
- Complex lab tests
- Hospitalization
- X-Rays

By my signature below I agree, as the parent or legal guardian of the student named above, that he/she may receive the services at the School-Based Wellness Center **(the "Wellness Center")**. I understand that the Wellness Center provides medical care for minor illness, mental health services, and health education.

It is the Wellness Center's philosophy that parents/guardians should be involved in their child's care. Therefore, the Wellness Center strongly encourages communication and involvement among students, parents and medical providers. I have the right to know about medical care my son/daughter receives for all services that are not considered confidential according to law.

THE GOLDEN KNIGHTS WELLNESS CENTER
HEALTH HISTORY FORM

A complete and accurate health history is needed in order for the staff to provide high quality health care. Services **will not** be provided unless this form is completed.

Student's Name_____ **Birthdate**_____ **Phone#**_____
Address: _____ **Male** ____ **Female** ____ **Grade** ____ **Age** ____
_____ **Social Security Number** _____

Race Codes: (Please circle one that applies)

I = American Indian/Alaska Native B = Black/African American A = Asian W = White
N = Native Hawaiian/Other Pacific Islander O = Other M = Mixed

Ethnicity Codes: (Please circle appropriate code)

Hispanic American Indian/Alaska Native Hispanic Black/African American Hispanic Asian
Hispanic White Hispanic Native Hawaiian/Pacific Islander

Who lives at home (father, mother, sister, brother) and how old are they?

Person	**Age**	**Person**	**Age**
1._____	____	5._____	____
2._____	____	6._____	____
3._____	____	7._____	____
4._____	____	8._____	____

Is the address you provided above: Permanent Shelter Institution Unstable/temporary
Foster Care Host Family Other

Will your son/daughter's be participating in the State Subsidized School Lunch Program this year? Yes ___ No ___

Is your son/daughter's enrolled in Special Education courses? Yes ___ No ___

Do any family members (parents, brothers, sisters, grandparents, aunts, uncles) **have any of the following problems** or have they had them in the past? If yes, **indicate which family member(s)** next to appropriate illness:

_____High Blood Pressure
_____Heart Disease/Heart Attack
_____Kidney Disease
_____High Cholesterol
_____Diabetes (sugar)
_____Thyroid Disease
_____Sickle Cell
_____Mental Illness
_____Stroke
_____Asthma
_____Tuberculosis
_____Cancer_____ (type or site)

Please check(√) any of the following illnesses or problems that your teen has now or has had in the past. Indicate with P=Past or C=Current

____Asthma
____Thyroid Disorder
____Sickle Cell Anemia
____Heart Problems
____Ulcers
____Fainting Spells
____Diabetes
____Head Injury/Headaches
____Seizures
____Mumps
____Measles
____Anemia
____Ear Infections
____Kidney Disease
____Colitis/Stomach Trouble
____Frequent Colds
____Tuberculosis
____Hemophilia
____Chicken Pox
____High Blood Pressure
____Arthritis
____Skin Problems
_____Mood Changes
_____Personal Hygiene
_____Menstrual Problems
_____Appears Withdrawn
_____Smokes\Chews Tobacco
_____Frequent Anger
_____Attempted Suicide
_____Change in Friends
_____Sleeping Problem
_____Eating Problem
_____Drug\Alcohol

PLEASE COMPLETE OTHER SIDE

THE GOLDEN KNIGHTS WELLNESS CENTER
HEALTH HISTORY FORM

When was son or daughter's last Tetanus Booster?_____ **Measles Booster (MMR)?**_____
(month/year) (month/year)
When was your son/daughter's Hepatitis B #1 _____ **Hepatitis B #2** _____ **Hepatitis B #3** _____
Month/Year Month/Year Month/Year

Please list any ALLERGIES your son or daughter has_____

Please list any MEDICATION your son or daughter takes_____

Who is your teen's Primary Care Physician? _____
Name Address Phone Number

Last visit? _____

Who is your teen's Dentist? _____
Name Address Phone Number

Last visit?_____

Please indicate your preferred pharmacy_____
Name Location Phone Number

Date of Teen's last physical exam: _____

Mothers only - Did you take any medication other than vitamins or iron when you were pregnant with this son or daughter?
If so, please list_____

The above medical information is accurate and complete.

_____
Signature of Parent/Legal Guardian **Date**

PLEASE COMPLETE OTHER SIDE

I understand that if I consent to my child receiving services at the Wellness Center then, according to state law, I also understand that: (i) I do not have the right to information about these “confidential services” provided to my child, unless my child gives permission to the Wellness Center to share that information with me; and (ii) the health care provider may, in its sole discretion, either provide or withhold information to me, having primary regard for the interests of the child.

School-Based Wellness Centers are funded through state funds and reimbursement from insurance for those students who have insurance. If my son/daughter has insurance I will provide this information to the Wellness Center. I understand that although the Wellness Center will not charge a co-pay or deductible, the Center may bill my insurance for covered services. I understand that my son/daughter can receive services at the Wellness Center regardless of ability to pay.

The Division of Public Health (DPH) retains administrative authority for School-Based Wellness Centers. Designated Wellness Team members are obligated by law to disclose specific patient information to DPH for the purpose of preventing or controlling disease, injury, surveillance, or disability in Delaware and in the US. Information that will be reported includes: laboratory data, births, deaths, adverse medication reactions, child abuse or neglect, and domestic violence. Other general information may be sent to DPH for statistical tracking, but this information will be de-identified during analysis, which means my son's/daughter's name will be removed. Information about services may be shared with my health insurance company for purposes of quality improvement.

I understand that this consent can be revoked in writing at any time, except to the extent that action has been taken in reliance on this consent. Any requests for revocation must be in writing and sent to the Wellness Center.

My son/daughter and I have read this form carefully and I understand that if I have any questions I may call the Wellness Center Coordinator for more information before I sign this authorization.

_____ _____
Signature of Parent/ Legal Guardian Date

_____ _____
Print Name of Parent/Legal Guardian Date

_____ _____
Signature of Student Date

_____ _____
Print Name of Student Date

_____
Street Address

_____
City State Zip Code