



Caregiver Consent for Health & Wellness School Based Services

Dear Parent/Guardian,

Eureka City Schools provides free support to help your child's well-being during the school day. Please review the information below and complete the consent form to allow your child to access these services.

What Services does the School Provide?

Your child may receive:

- ✓ Social-emotional and skill-building groups
- ✓ School nursing services
- ✓ School Counseling Services
- ✓ Classroom Health and Wellness lessons
- ✓ Case management and referrals to additional services
- ✓ Wellness check-ins and other healthcare support
- ✓ Mental health counseling (grief, anger management, substance use, etc.)

Who is on the Health and Wellness Team?

The team may include:

- ✓ School-based specialists (mental health counselors, social workers, psychologists, school nurses)
- ✓ Community-based therapists, behavioral health professionals
- ✓ Trainees (supervised by licensed professionals)

How Does Billing Work?

- ✓ **You will NOT be charged** for any services your child receives.
- ✓ If your child has insurance (Medi-Cal, private, or commercial), it **may be billed** for services, but you **will never receive a bill or copay** from the school or your insurance provider.

Privacy & Information Sharing

- ✓ All health and service records are **confidential** and stored securely.
- ✓ The Wellness Center team **only shares information as needed** to coordinate care.
- ✓ Some details may be shared with school staff (such as counselors or teachers) **on a need-to-know basis** to support your child.
- ✓ General, non-identifiable service data may be shared for research, program evaluation, and continued funding



Consent & Signature

This consent is **valid for one year** and must be renewed annually. You may withdraw consent at any time.

Student & Insurance Information

Student Name: _____ Date of Birth: _____

Caregiver (Legal Guardian) Name: _____

My student does not have insurance

Primary Insurance Provider: _____

Insurance Cardholder's Name: _____ Date of Birth: _____

Policy Number: _____

Relationship to Cardholder (Select one): Self Child Parent Other: _____

Secondary Insurance Provider (if applicable): _____

Insurance Cardholder's Name: _____ Date of Birth: _____

Policy Number: _____

Relationship to Cardholder (Select one): Self Child Parent Other: _____

Caregiver Signature: _____ **Date:** _____