DEPARTMENT OF HEALTH AND HUMAN SERVICES

School Based Health and Wellness Centers

Health services are available to ALL children
Enrolled at School Based Health and Wellness Centers!

Montgomery County Department of Health and Human Services' School Based Health and Wellness Centers (SBHWCs) provide health services, including preventive health care and sick care, to enrolled students *right in the school building*. Many students are able to be treated and return to class rather than being sent home! In most cases, parents do not have to leave work for their children to receive health services!

Services include:

- annual physical examinations
- sports physicals
- diagnosis and treatment of illness and injury
- immunizations
- medications dispensed at the sites
- laboratory work

Annual physical examinations keep children well and in school, and are recommended by the American Academy of Pediatrics.

New enrollees must complete and submit an enrollment packet. To obtain an enrollment packet, please contact the SBHWC located at your child's school.

Current enrollees should update their information on file, as needed.

Students and their families will not receive a bill for health services provided in the SBHWC.

All enrolled children will be seen regardless of their insurance status.

If your child has health care coverage that participates with Montgomery County, the insurer may be billed for services provided to your child. If your child is not insured please indicate that on your enrollment form and you will be contacted by a School Based Health and Wellness Center staff member who will assist you to apply for the Maryland Children's Health Program (HealthChoice) or the Care for Kids program.

If you have any questions, please contact the School Based Health and Wellness Center at your school.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
School Based Health and Wellness Centers

Enrollment Form

SBHWC Location: **Student ID #:**

Student's Name_____ **Home School**_____**Grade**_____

Date of Birth_____**Social Security # _ _ _ - _ _ - _ _ _ _ Gender** ____**Race/Ethnicity**_____

Address _____ **Home Phone**_____

City _____**State** _____**Zip Code**_____**Student Phone**_____

Country of Birth _____**Primary Language spoken at home** _____

Student's Primary Health Care Provider_____**Phone**_____

Parent/Guardian _____ **Date of Birth**_____ **Phone #**_____

Other Emergency Contact_____ **Contact's Phone #** _____

Contact's Relationship to Child_____

I give permission for my child, _____, to enroll in the School Based Health/Wellness Center (SBHWC). I consent to his/her receiving services which may include complete physical examinations, immunizations, treatment for chronic and acute health problems, health screenings, limited laboratory and diagnostic tests, administration/prescribing of medications, health education, case management and /or referrals to mental health and social services. I give permission for SBHWC health and mental health professionals and School Health Services staff to share information or records as needed to provide appropriate services to my child through the SBHWC and support my child's success in school.

I understand:

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the School Based Health/Wellness Center (SBHWC).
- All SBHWC records are confidential and only the SBHWC staff and providers will have access to a child's SBHWC records and information, unless the parent/guardian gives written consent, or the minor patient gives written consent, in the event the minor is receiving treatment for which the minor has the authority to consent.
- At this time, Maryland law does not require parental consent or notification for the following services provided by the SBHWC: treatment or advice about drug abuse, alcoholism, sexually transmitted infections, pregnancy or contraception to minors under 18 years of age, and mental health services to minors age 16 years or older.
- Services at the SBHWC will be provided by staff employed by or contractors with Montgomery County Department of Health and Human Services.
- If my child has health insurance through an insurance company that participates with Montgomery County, the insurer will be billed for services given in the SBHWC and the insurer may be provided required information about the child's health status or other information necessary to process insurance claims.
- If my child does not have health insurance, I will indicate on my enrollment form and I will be contacted by SBHWC staff to assist in applying for Maryland Children's Health Program (HealthChoice) or Care for Kids coverage.
- I am authorizing any payment of medical benefits for services rendered in the SBHWC to be directed to Montgomery County.
- **All enrolled children will be seen regardless of their insurance status and I will not receive a bill for services provided in the SBHWC.**

I understand the description of services and policies of the SBHWC as stated above and give permission for my child to enroll and receive services in the SBHWC. I understand that this permission can be withdrawn at any time by submitting notice in writing.

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

Print Name _____ **Relationship to Student**_____

Date Form Completed _____ **SBHWC Location** _____

Montgomery County Department of Health and Human Services
School Based Health and Wellness Center

Health Insurance Information

Student's Name _____ _____ _____
(last) *(first)* *(middle)*

School _____ Date of Birth _____

Name of Child's Doctor _____ Doctor's Phone Number _____

Date of Last Physical Exam _____

Please complete the information below. Please provide a copy of your insurance card. Your insurance company may be billed.

Parent/Guardian Name: _____ Date of Birth _____

Parent/Guardian Name: _____ Date of Birth _____

Number of Family Members _____ Family Income _____ weekly monthly yearly (please circle)

Does your child have health coverage? _____ Yes _____ No

*If **Yes**, please check and complete **one** of the following:*

☐ My Child is enrolled in the Care For Kids Program PULS #_____

☐ My Child has Medical Assistance (HealthChoice) *Complete below and attach a copy of HealthChoice card, if available*

Child's Medical Assistance Number ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Child's Managed Care Organization _____
(*If you have not selected an MCO, write "none")*

☐ My Child has private health insurance *Complete below and attach a copy of health insurance card, if available*

Name of Policy Holder _____

Relationship to Child _____

Social Security or ID Number of Policy Holder _____

Policy Holder's Place of Employment _____

Name of Insurance Company _____

Insurance Billing Address _____

_____

All children will be seen regardless of their insurance status and will not receive a bill for services provided at the SBHWCs

PLEASE RETURN THIS FORM TO YOUR SCHOOL NURSE

SCHOOL BASED HEALTH and WELLNESS CENTER

Consent to Administer Over the Counter Medications to Enrolled Students

The medications listed below are stocked at the School Based Health and Wellness Centers. If your child is **enrolled** for services, he/she may be given one of these medications, if in the judgment of the school nurse or nurse practitioner they might be helpful. You will be notified by telephone or by note, if and when your child is given of these medications.

To give your permission for your child to take any of these medications, please check **YES** below. If you do not want your child to receive one or more of these medications, check **NO.**

ASPIRIN SUBSTITUTE (acetaminophen {Tylenol}) ____YES ____NO
-For fever greater than 100.4˚ and/or discomfort/pain.

ANTIHISTAMINE (Loratidine {Claritin}) ____YES ____NO
-for allergic reaction and/or nasal congestion.

ANTIHISTAMINE (diphenhydramine hydrochloride {Benadryl}) ____YES ____NO
-for allergic reaction and/or nasal congestion.

Child's Name_____DOB____/____/____ Grade_____

Parent/Guardian Signature_____Date____/____/____

SBHWC 308-1A-EN 08/15

Montgomery County Department of Health and Human Services

Notice of Privacy Practices Summary and Signature Page

What is the Notice of Privacy Practices?

We are required by law to provide you with a notice of our privacy practices. Our complete *Notice of Privacy Practices* is attached. The purpose of the *Notice* is to inform you about:

- Our legal obligation to protect your information.
- How we will share your information without your written permission.
- Rights that you have related to your information.
- Who you can contact to ask questions, make a request, or file a complaint.

How will we share your information?

Our Department provides a variety of health, income support and social services. To provide these services, we must ask you for personal information that may contain health, financial and other information that identifies you. We will keep your information safe and will only share it when the law permits us or requires us to do so. We will share your information as necessary to:

- Provide you with high quality and coordinated treatment and services. Example: Communicating information between programs to make referrals, determine eligibility or develop a care plan;
- Obtain payment for services. Example: Billing Medicaid;
- Manage our services and programs. Example: Reviewing the quality of the services you receive.

The attached *Notice* lists other reasons why we may share your information. If we need to share your information for reasons that are **not** listed, we will ask for your written permission. You have other rights related to your information that are listed on page 4 of the *Notice.*

Contact Information:

If you have questions about our privacy practices, want to make a request related to your information, or have a privacy concern, contact the staff person who is working with you, or our Privacy Official at 240 777- 3050. Additional contact information is provided at the end of the *Notice.*

Acknowledgement of receipt of the complete *Notice*:

_____ _____

Client or Authorized Representative (Sign your name) Date

_____

Print your name

_____ _____

Signature of DHHS representative Signature of interpreter/translator if applicable

If unable to get acknowledgement, specify why: _____

SCHOOL BASED HEALTH AND WELLNESS CENTER
STUDENT HEALTH HISTORY

Patient Name:	Date of Birth:	Sex: (circle) Male Female
Form Completed By: / Today's Date	Relationship:	

PREGNANCY AND BIRTH HISTORY

Name of Hospital: _____
Illnesses during pregnancy? No ☐ Yes ☐
Medications during pregnancy? No ☐ Yes ☐
Alcohol/Drug Abuse? No ☐ Yes ☐
Problems at birth? No ☐ Yes ☐
Describe: _____
Type of delivery? ☐ Vaginal ☐ C-section
Birth Weight_____Discharge Weight_____
Did baby receive Hepatitis B vaccine? No ☐ Yes ☐
Date of Hepatitis B immunization:_____
Newborn Hearing Screen? No ☐ Yes ☐

PSYCHOSOCIAL HISTORY

Who lives in household?_____
_____
How many?_____
☐ Rent? ☐ Own? ☐ Shelter?
Who cares for child?_____
Date of Birth? Mother_____
Father_____
Are parents working? Mother No ☐ Yes ☐
Father No ☐ Yes ☐
Foster Care? _____Dates:_____
Other Languages?_____

FAMILY HISTORY

Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:

			Who?
Allergies (List) _____	No ☐	Yes ☐	_____
_____			
Asthma	No ☐	Yes ☐	_____
TB/Lung Disease	No ☐	Yes ☐	_____
HIV/AIDS	No ☐	Yes ☐	_____
Suicide Attempts	No ☐	Yes ☐	_____
Heart Disease	No ☐	Yes ☐	_____
High Blood Pressure/Stroke	No ☐	Yes ☐	_____
High Cholesterol	No ☐	Yes ☐	_____
Blood Disorders/Sickle Cell	No ☐	Yes ☐	_____
Diabetes	No ☐	Yes ☐	_____
Seizures	No ☐	Yes ☐	_____
Mental Illness	No ☐	Yes ☐	_____
Cancer	No ☐	Yes ☐	_____
Birth Defects	No ☐	Yes ☐	_____
Hearing Loss	No ☐	Yes ☐	_____
Speech Problems	No ☐	Yes ☐	_____
Kidney Disease	No ☐	Yes ☐	_____
Alcohol/Drug Abuse	No ☐	Yes ☐	_____
Hepatitis/Liver Disease			
Thyroid Disease	No ☐	Yes ☐	_____
Learning Problems/Attention	No ☐	Yes ☐	_____
Deficit Disorder	No ☐	Yes ☐	_____
Family Violence	No ☐	Yes ☐	_____

Other: _____
_____

MEDICAL HISTORY

Has your child ever had:

Allergies (List) _____	No ☐	Yes ☐
_____		
Asthma	No ☐	Yes ☐
Chicken Pox (Year) ___	No ☐	Yes ☐
Frequent Ear Infections	No ☐	Yes ☐
Vision/Hearing Problems	No ☐	Yes ☐
Skin Problems/Eczema	No ☐	Yes ☐
TB/Lung Disease	No ☐	Yes ☐
Seizures/Epilepsy	No ☐	Yes ☐
High Blood Pressure	No ☐	Yes ☐
Heart Defects/Disease	No ☐	Yes ☐
Liver Disease/Hepatitis	No ☐	Yes ☐
Diabetes	No ☐	Yes ☐
Kidney Disease/Bladder Infections	No ☐	Yes ☐
Physical or Learning Disabilities	No ☐	Yes ☐
Bleeding Disorders/Hemophilia	No ☐	Yes ☐
Sexually Transmitted Diseases	No ☐	Yes ☐
Emotional or Behavioral Problems	No ☐	Yes ☐
Depression/Suicidal Thoughts	No ☐	Yes ☐
Hospitalizations/Surgeries	No ☐	Yes ☐
Physical/Emotional/ Sexual Abuse	No ☐	Yes ☐
Bone or Joint Injuries	No ☐	Yes ☐
Obesity/Eating Disorders	No ☐	Yes ☐
Other: _____	No ☐	Yes ☐
_____		

Current Medication(s): (*List*) _____
_____

Reviewed by:	Date of Review: