**PARENTAL CONSENT FORM FOR DUNDALK SECONDARY WELLNESS CENTER**

I am granting permission for my child to enroll in the Comprehensive School-Based Wellness Center and consent to his/her receiving health related services which can include physical examinations, health screenings, limited diagnostic tests, education, counseling, referrals, and administration of necessary medications. I understand the school nurse is responsible for follow-up care and will have access to the Wellness Center records. You have my permission to release any Wellness Center information to any health or mental health professional providing services to my child through the Wellness Center. You have my permission to release any educational information to any health or mental health professional who needs this information to care for my child through the Wellness Center.

* **My signature on this consent certifies that I have received Baltimore County Department of Health Notice of Privacy Practices.**
* **I understand that Maryland Law allows a minor to receive treatment and/or advice about sexually transmitted disease, pregnancy, drug abuse, mental health (16 years of age or older), and contraception.**
* **My signature authorizes my child to walk to the Dundalk Wellness Center alone, without adult escort, during school hours, if based on the sound medical judgment of the school nurse; he/she is able to do so.**
* I understand that I am responsible for medical care if follow-up outside the school-based center is recommended.
* I authorize the release of any medical or other information necessary to process insurance claims, if applicable.
* I authorize payment of medical benefits to Baltimore County for services rendered at the Wellness Center.
* I agree that if I receive payment from my insurance company for services rendered at a Wellness Center, I will endorse the check and forward it to the Wellness Center.
* I understand that if my child is registered with a Managed Care Organization (MCO) through Medical Assistance, he/she can still receive treatment for acute or urgent health problems from the school health center.
* I understand that my child’s immunization record will be entered on the Maryland registry, ImmuNet, if vaccines are given.

Print Child’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_

Child’s Social Security Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Male Female

Child’s Health Care Provider\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Parent/Guardian\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mother’s Maiden Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Legal Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOUR CHILD HAS MEDICAL ASSISTANCE, PLEASE COMPLETE THE FOLLOWING INFORMATION:**

Child’s Medical Assistance Number: \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_ \_\_\_\_

Child receives MA services through an MCO? \_\_\_\_\_\_YES \_\_\_\_\_\_NO

If YES, name of MCO\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOUR CHILD’S HEALTH CARE IS COVERED BY PRIVATE INSURANCE, PLEASE COPY ALL THE FOLLOWING INFORMATION DIRECTLY FROM YOUR INSURANCE CARD:**

1. Insurance Company’s Name & Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company’s CLAIMS (Billing) Address (if different from above)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Company’s Phone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name of Individual listed on Insurance Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number of Insured Listed on Card \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Group Number Listed on Health Insurance Card\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. List the name of the Policy Holder (person whose name the insurance policy is under)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security Number of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of Employment of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number (\_\_ \_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of Policy Holder to Child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address of Policy Holder\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IF YOUR CHILD HAS NO HEALTH CARE COVERAGE THROUGH AN HMO, MEDICAL ASSISTANCE, OR PRIVATE INSURANCE, PLEASE INDICATE BY PLACING A (√) IN THIS SPACE. ( ) AND COMPLETE BELOW.**

**Please indicate Annual Income: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of Family Members: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**If you need help with Medical Assistance, please call the Office of Third Party Billing: 443-809-4130**

**PLEASE RETURN THIS FORM TO THE SCHOOL NURSE!**

BEBCO 3646--18 (2NCR)