



**MIDDLETOWN HIGH SCHOOL-BASED WELLNESS CENTER
PARENTAL CONSENT FOR TREATMENT**

Please print

I, _____ give my consent for _____
Parent/Guardian Name *Student Name*

to receive services at the Wellness Center administered by the Division of Public Health located at the Middletown High School.

If you wish to **DECLINE** a service listed for your child, **CROSS OUT** that specific service.

PHYSICAL HEALTH CARE

- Routine sports and employment physicals
- Acute colds, sore throats, and flu
- Minor illnesses and injuries
- Prescriptions
- Immunizations
- Tuberculosis exposure screening
- Follow up as requested by family physician
- Diagnosis and treatment of sexually transmitted disease
- Identification & referral of chronic illness
- The use of condoms as a method of disease prevention for persons who chose not to be abstinent is discussed and condoms are distributed **only** to infected sexually active persons as a means of preventing the spread of infection.

COUNSELING

- Individual group & family
- Counseling and referral for ADD/ADHD
- Support for parents of adolescents
- Suicide prevention
- Stress, anxiety & depression
- Drug & alcohol counseling and referral
- Counseling and referral for HIV/Aids
- Referral for outpatient counseling

NUTRITION

- Sports Nutrition
- Weight management
- Special diets
- Referral for eating disorders
- Nutrition education

EDUCATION

- Individual and group education
- Smoking Prevention/Cessation
- Self-esteem
- Stress management
- Substance abuse
- Family planning referral
- Conflict resolution
- Teenage health issues

LAB SCREENINGS

- Routine lab tests
- Throat cultures
- Pregnancy tests
- STD tests
- HIV tests

The Wellness Center at Middletown High School **WILL NOT** provide the following services:

- Hospitalization
- Birth control
- Treatment of complex medical or psychiatric conditions
- X-rays
- Complex lab tests
- Referrals for abortions

I understand the Wellness Center staff will work closely with my teen's primary care provider. If he/she does not already have a primary care provider, I will work with the Wellness Center to choose one.

I understand that visits to the Wellness center will be strictly confidential (except for threat to harm oneself and/or others, or child abuse). Access to medical records requires a written release signed by the student. Release of any medical records to another agency or medical provider requires consent to release information as specified in the Division of Public Health's Notice of Privacy Practices (HIPAA). This practice conforms with Federal law governing all medical facilities.

I have had the opportunity to receive and review the Division of Public Health's Notice of Privacy Practices.

I have completely disclosed all information requested on the Health History form.

I understand that most services are provided at no cost to my family unless notified otherwise prior to the services being provided. Insurance or Medical Assistance will be billed whenever possible and agreeable to students and parents.

Consents for services may be withdrawn or modified at any time by the parent/guardian or student.

I have read and completed this consent form. I understand that any questions I may have concerning the Wellness Center can be answered by calling the Staff at the Wellness Center, 378-5775.

**PLEASE RETURN YOUR COMPLETED FORM TO THE WELLNESS CENTER OR SCHOOL NURSE.
YOU MAY ALSO MAIL YOUR FORM TO:**

Middletown High School - Based Wellness Center
122 Silver Lake Road
Middletown, DE 19709

Signature of Parent/Guardian

Relationship

Date