

**PLEASE COMPLETE OTHER SIDE**

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.

The District School Board has approved that diagnosis and treatment of sexually transmitted diseases and reproductive health services be provided in the Wellness Center. These services are considered confidential according to state law, and are designated "confidential" on the other side of this form. I understand that if I consent to my son/daughter receiving any Wellness Center service, then by state law I also understand that:

- My son/daughter may consent to confidential services without my permission; and
- I do not have the right to information about confidential services provided to my son/daughter, unless my son/daughter gives permission to the Wellness Center to share that information with me.

*written*

*I DO NOT HAVE THE RIGHT AS A PARENT???*

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.

*Contradictory!!*

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 the Wellness 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: sexually transmitted disease, 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.

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

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Student

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

*# ?  
Contact name # ?  
email ???*

*Do NOT SUPPORT THIS Fundamentally Flawed Bill.*

*While we understand the need to bill insurance - THIS Bill exposes a fundamental Parental Rights ISSUE IN OUR STATE!!!*

*Do NOT SUPPORT THIS Bill - SB135*

*The language of this form fundamentally VOIDS Gerald Hecker's Parental Rights amendment!!*

### 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 \_\_\_\_\_ Wellness Center  
(Name of High School)

administered by: \_\_\_\_\_ Telephone Number: \_\_\_\_\_  
(Name of Medical Vendor)

#### MENU OF SERVICES

**As a Parent or guardian you can choose whether your child can receive services at the Wellness Center. You have a right to information about any of these services provided to your minor (less than 18 years) child.**

#### 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 test, dispensing non-prescription medication and/or providing prescription medication)
- Physical examinations, including sports/employment physical
- Immunizations in accordance with the Division of Public Health
- Coordinating services with student's Primary Health Care Provider /other Provider
- Referral of a student who does not have a primary care provider to a physician
- Drug, alcohol and other substance abuse counseling and referral
- Nutrition counseling

#### COUNSELING

- Individual counseling
- Group counseling
- Family Counseling
- Referrals for long-term counseling or other evaluations

#### EDUCATION

- Individual and group programs focusing on healthy life choices

#### CONFIDENTIAL SERVICES

**The following confidential services are offered by this school. If you consent to your child receiving services at the Wellness Center, then according to Delaware Law (Title 13 §710) your child can receive confidential services without your consent. You do not have the right to information about these services unless your child gives the Wellness Center permission to share that information.**

- Condoms
- Oral contraception to prevent pregnancy
- Pregnancy screening *Then what? Referrals? That I won't know about!*
- Diagnosis and treatment of sexually transmitted diseases *Then counseling that I'll know nothing about?*

#### 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

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