



PLEASE PRINT (**One** student per form)

Student's Name _____ Date of Birth _____ Social Security # _____ - _____ - _____

Address _____ City _____ State _____ ZIP _____

Home phone # _____ Sex (circle) M F Grade _____ School _____

Parent/Guardian Name _____ Date of Birth _____ Relationship to Student _____ Phone # Home/Work _____

Emergency contact person _____ Phone # _____ Relationship to student _____

Family Physician/Clinic _____ None _____ Phone # _____

Student/ Name of Insurance _____ Policy/Group # _____

Allergies/Health Problems, Medications (please explain here) _____

School-Based Wellness Center
PARENTAL CONSENT TO TREATMENT AND DISCLOSURE

We are glad you are enrolling your child in the School-Based Wellness Center (SBWC) program. Please read this consent form carefully and complete the above information to enroll your child.

By signing below, I attest that I am the parent or legal guardian for the student named on this form and I give my consent for the student to receive services available through the SBWC program from the staff at the SBWC under the conditions described below.

Primary care services provided. The services at the SBWC are comprehensive primary care/behavioral health services and are comparable to that which would be received at a private, family practice physician's office, private behavioral health counseling office or a clinic including individual and family therapy, patient education, and immunizations (immunizations may require a *separate* parental consent). Health care and behavioral health care services are delivered to students in accordance with prevailing standards of care in the medical/behavioral health community to assure the highest quality care.

Parental involvement and notification. Colorado law may prohibit the SBWC from informing parents/guardians, without the child's permission, of mental health problems, substance abuse, eating disorders, pregnancy matters, family planning, including birth control, and diagnosis or treatment of sexually-transmitted diseases. For the purpose of these conditions, the child may enter into a confidential and privileged relationship with the SBWC provider. However, it is the SBWC's practice to gain permission from the student to inform their parent(s) or a caring adult when one or more of these conditions are present. When permission is not granted, the SBWC staff will strongly encourage the student to communicate their condition to their parent(s). Parents with questions about SBWC services are encouraged to contact the SBWC with their inquiries.

Confidentiality and use of the student's protected health information. I consent to the SBWC disclosing all or any portion of my son's/daughter's protected health information to our family physician(s) or primary care provider, the school's nursing staff, and other SBWC staff as needed. I also give consent to the SBWC staff to examine my son's/daughter's school records, attendance, and other records to assist the staff with helping my son/daughter. The SBWC may release information regarding treatment to third party payers for the purpose of billing, and for any reason in accordance with acceptable medical practice pursuant to State law and in accordance with Federal privacy regulations. I understand refusal to authorize disclosure of my child's personal medical information will have no effect on my child's enrollment, eligibility for benefits or the amount that health insurance may pay for health services received. The personal medical information that I authorize to be disclosed may be subject to redisclosure and no longer protected by law.

Financial responsibility. Due to the cost of services the SBWCs provide, we may bill any insurance covering the student. In the event the student does not have insurance, we will provide treatment; however, we will require that the parent/guardian complete a financial eligibility screening to determine if the student qualifies for any health care programs that help with the cost of his/her care. Fees for immunizations are separate. Co-payments and/or deductibles associated with any health insurance or other health care coverage your child has will be assessed and collected. In addition, it may be necessary to refer students to the hospital, specialists, or other health care providers for recommended treatment in order to provide quality health care. These providers may have separate charges for these services and will be the responsibility of the student/parent/guardian.

Acknowledgement and termination of this consent form. I understand this consent will remain in force until my son/daughter leaves his/her school, and that I may revoke this authorization at any time, in writing, except to the extent that the SBWC has already acted on my permission. It is the parent/guardian's responsibility to notify the school about changes in guardianship. I have read and completed this consent form. I may call the SBWC with any questions I have.

DATE

SIGNATURE OF PARENT/GUARDIAN