BALTIMORE COUNTY PUBLIC SCHOOLSTOWSON, MARYLAND 21204

BALTIMORE COUNTY DEPARTMENT OF HEALTH
BALTIMORE, MARYLAND 21212

PARENTAL CONSENT FORM FOR ELEMENTARY WELLNESS CENTER

I am granting permission for my child to enroll in the School-Based Wellness Center and consent to them 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 may participate in coordinating follow-up care and will have access to the Wellness Center records. You have my permission to release any Wellness Center health information to any health or mental health professional providing services to my child through the Wellness Center, school health suite, or school counseling office. 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 mental health (12 years of age or older).
- 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 has health insurance through Medical Assistance, with or without a Managed Care Organization (MCO), they can still receive care from the Wellness 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 ☐ Other
Child's Health Care Provider____ Telephone________________________
Print Name of Parent/Guardian____
Mother's Maiden Name ____
Relationship to Student Telephone (H)_______________ (W)________________

Signature of Parent/Legal Guardian_____________________________________ Date,__________________

IF YOUR CHILD HAS ANY FORM OF HEALTH INSURANCE, PLEASE PROVIDE A COPY OF THEIR INSURANCE CARD.

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 Policy/Contract# Effective Date:

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 (may be social security number)_____________________
   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____

   Relationship of Policy Holder to Child Work Phone Number
   Home Address of Policy Holder

IF YOUR CHILD HAS NO HEALTH CARE COVERAGE, PLEASE INDICATE BY PLACING A (√)HERE( ) AND COMPLETE BELOW.

Please indicate Annual Income:________________ Number of Family Members: ______________

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE!