Sussex Tech Wellness Center

17099 County Seat Highway | Georgetown, DE 19947 | Phone: 302-271-2522 | Fax: 302-856-6359

Dear Parent/Guardian:

The Wellness Center at Sussex Vocational Technical High School would like to invite your high school student to become a member of the wellness center. At the wellness center students can get sports physicals, treatment for minor illness and injuries, flu vaccine and immunizations.

We also offer mental and emotional health counseling. We are here to help students who are experiencing life stressors and may be having difficulty at home feeling sad or having anxiety.

A nutritionist is available to provide well health, nutrition counseling, consult for weight/underweight and sports optimization.

Services are available to all students regardless of insurance status. Please complete the attached forms and return to the Wellness Center. Please call with any questions or to schedule an appointment (302) 271-2522. We are here to help.

Sincerely,
Beebe Sussex Tech Wellness Center

Sussex Vo-Technical High School
Wellness Center
Patient Registration Form

Patient Information — Please Print

Today's Date:	Primary Care Provider:		
Patient's Last Name: First: Middle:		Male ☐	Female ☐
Race (please circle all that apply): Caucasian/White Black/African American Asian/Native Hawaiian/Other Pacific Islander American Indian/Alaskan Native	Ethnicity (please circle): Hispanic/Latino Arabic Non-Hispanic/Latino/Arabic		
Address:	Phone#:		
SSN#:	Birth date:		

Parental/Legal Guardian Information

Mother's Full Legal Name:	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	
Father's Full Legal Name:	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	
Legal Guardian Name (if not mother or father):	SSN#:	Birth date:
Address:	Home Phone#:	
Employer Name & Address:	Employer Phone#:	

Insurance Information

Medicaid #:	Name of Medicaid Health Plan:			
Is Medicaid your only insurance? Yes No	If Medicaid is NOT your only insurance, or you do not have Medicaid, please list your information below.			
Primary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
Secondary Insurance Name:			Subscriber Name:	
Group#	Subscriber DOB:		Policy#:	
Patient Relationship to Subscriber	Self ☐	Spouse ☐	Child ☐	Other ☐
In case of an emergency contact:	Relationship to patient:		Phone #:	
Is patient employed? Yes No	Patient's yearly income	Household yearly income:	# of family members in household:	
Parent/Legal Guardian Signature:			Date:	

SUSSEX TECH HIGH SCHOOL- 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 Sussex Tech High School Wellness Center (the "Wellness Center") administered by Beebe Healthcare (Telephone Number 302-271-2522) **Students must have parental written consent to receive Wellness Center services.**

MENU OF SERVICES

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 tests, COVID testing, dispensing non-prescription medication and/or providing prescription medication)
- Physical examinations, including sports/employment physicals
- Immunizations in accordance with the Division of Public Health
- Coordinating services with student's Primary Health Care Provider
- Referral of a student who does not have a primary care provider to a physician
- Nutrition services and referrals

COUNSELING

- Individual counseling
- Group counseling
- Family counseling
- Drug, alcohol and other substance abuse counseling and referrals
- Referrals for long-term counseling or other evaluations

EDUCATION

- Individual and group programs focusing on healthy life choices

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

CONFIDENTIAL SERVICES

The following confidential services are offered by the Wellness Center. According to Delaware Law (Title 13 §710), your child, 12 years or older, may provide the required consent him/herself to receive these services:

- Pregnancy testing
- Diagnosis and treatment of Sexually Transmitted Infections
- Contraceptives

I understand that if I consent to my child receiving services at the Wellness Center then, according to state law, I also understand that: (i) I do not have the right to information about these "confidential services" provided to my child, unless my child gives permission to the Wellness Center to share that information with me; and (ii) the health care provider may, in its sole discretion, either provide or withhold information to me, having primary regard for the interests of the child.

Parent Initial __________

CONSENT

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. I understand that the Wellness Center provides medical care for minor illness, mental health services, reproductive health (confidential services) and health education.

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.

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 although the Wellness Center will not charge a co-pay or deductible, the 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: 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. Information about services may be shared with my health insurance company for purposes of quality improvement.

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 child 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

THE RAVEN WELLNESS CENTER
HEALTH HISTORY FORM

A complete and accurate health history is needed in order for the staff to provide high quality health care. Services **will not** be provided unless this form is completed.

Student's Name________________________________ **Birthdate**______________ **Phone#**______________
Address: ________________________________ **Male** ____ **Female** ____ **Grade** ____ **Age** ____
________________________________ **Social Security Number** ______________________

Race Codes: (Please circle one that applies)

I = American Indian/Alaska Native
B = Black/African American
A = Asian
W = White
N = Native Hawaiian/Other Pacific Islander
O = Other
M = Mixed

Ethnicity Codes: (Please circle appropriate code)

Hispanic American Indian/Alaska Native
Hispanic Black/African American
Hispanic Asian
Hispanic White
Hispanic Native Hawaiian/Pacific Islander

Who lives at home (father, mother, sister, brother) and how old are they?

Person	Age	Person	Age
1.________________	____	5.________________	____
2.________________	____	6.________________	____
3.________________	____	7.________________	____
4.________________	____	8.________________	____

Is the address you provided above: Permanent Shelter Institution Unstable/temporary Foster Care Host Family Other

Will your son/daughter's be participating in the State Subsidized School Lunch Program this year? **Yes** ___ **No** ___

Is your son/daughter's enrolled in Special Education courses? **Yes** ___ **No** ___

Do any family members (parents, brothers, sisters, grandparents, aunts, uncles) **have any of the following problems** or have they had them in the past? If yes, **indicate which family member(s)** next to appropriate illness:

________High Blood Pressure
________Heart Disease/Heart Attack
________Kidney Disease
________High Cholesterol
________Diabetes (sugar)
________Thyroid Disease
________Sickle Cell
________Mental Illness
________Stroke
________Asthma
________Tuberculosis
________Cancer__________ (type or site)

Please check(√) any of the following illnesses or problems that your teen has now or has had in the past. Indicate with P=Past or C=Current

____Asthma
____Thyroid Disorder
____Sickle Cell Anemia
____Heart Problems
____Ulcers
____Fainting Spells
____Diabetes
____Head Injury/Headaches
____Seizures
____Mumps
____Measles
____Anemia
____Ear Infections
____Kidney Disease
____Colitis/Stomach Trouble
____Frequent Colds
____Tuberculosis
____Hemophilia
____Chicken Pox
____High Blood Pressure
____Arthritis
____Skin Problems
____Mood Changes
____Personal Hygiene
____Menstrual Problems
____Appears Withdrawn
____Smokes\Chews Tobacco
____Frequent Anger
____Attempted Suicide
____Change in Friends
____Sleeping Problem
____Eating Problem
____Drug\Alcohol

PLEASE COMPLETE OTHER SIDE

THE RAVEN WELLNESS CENTER
HEALTH HISTORY FORM

When was son or daughter's last Tetanus Booster?____________ **Measles Booster (MMR)?**____________
(month/year) (month/year)

When was your son/daughter's Hepatitis B #1 __________ **Hepatitis B #2** __________ **Hepatitis B #3** __________
Month/Year Month/Year Month/Year

Please list any ALLERGIES your son or daughter has________________________________

Please list any MEDICATION your son or daughter takes________________________________

Who is your teen's Primary Care Physician? ________________________________
Name Address Phone Number

Last visit? ____________________

Who is your teen's Dentist? ________________________________
Name Address Phone Number

Last visit?____________________

Please indicate your preferred pharmacy________________________________
Name Location Phone Number

Date of Teen's last physical exam: ______________

Mothers only - Did you take any medication other than vitamins or iron when you were pregnant with this son or daughter? If so, please list________________________________

The above medical information is accurate and complete.

____

Signature of Parent/Legal Guardian **Date**

PLEASE COMPLETE OTHER SIDE

HIGH SCHOOL HEALTH (WELLNESS) CENTERS

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

Effective April 14, 2003, the Wellness Center must comply with the Privacy Rules as detailed in the Health Insurance Portability and Accountability Act ("HIPAA"). By law we are required to provide you with a copy of the Wellness Center's Notice of Privacy Practices. The Notice describes how the Wellness Center may use and disclose health information about the student. It also explains how you can get access to this information.

The Wellness Center is committed to taking steps in compliance with applicable law, to protect your privacy and confidentiality. We want you to know that we may use your health information for purposes of your treatment, to obtain payment for services that we provide to you and for purposes of Wellness Center operations. For more information on how we may use and disclose your health information, please read our Notice of Privacy Practices.

The terms of Notice may change. The most current Notice will always be posted in the Wellness Center. You may also contact the Wellness Center staff to obtain the most current copy.

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I hereby acknowledge that I have received a copy of Beebe Healthcare's Wellness Center Notice of Privacy Practices:

Name of Student:______________________________ Date of Birth: _________

Student's Signature: ___________________________ Date: ___ / ___ / ___

OR (only one signature is required)

____ Date: ___ / ___ / ___

(Parent/Legal Guardian's Signature)

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

Form #: M-20280 10/28/04, 8/4/15

SUSSEX VO-TECHNICAL WELLNESS CENTER

17099 County Seat Hwy
Georgetown, DE 19947
(302) 271-2522 Phone
(302) 856-6359 Fax

PATIENT RIGHTS AND RESPONSIBILITIES

Beebe Healthcare, in recognition of your rights as a patient and of its responsibility to provide quality health care, affirms these rights for all patients and their visitors. Should you need clarification or have a concern about your rights or responsibilities, please contact the Wellness Center at 302-271-2522.

YOU HAVE THE RIGHT TO:

- Considerate and respectful care;
- Having your communication needs met – such as interpreter services, large print documents, etc..;
- Be well-informed by your provider about your illness, possible treatments, and likely outcome;
- Consent to or refuse a treatment, as permitted by law, throughout your visit;
- Know the name and professional role of your healthcare provider;
- Personal privacy during all patient care activity, and when requested;
- To receive care in a setting including free of all forms of abuse or harassment;
- Access protective services when necessary;
- Expect that all treatment records and medical care are confidential, unless you have given permission for release of information or reporting that is required by law;
- Review your medical records and have the information explained;
- Have a family member (or other representative) and your own physician notified promptly of your admission to the hospital;
- Receive necessary health services to the best of the medical centers ability. Treatment, referral, or transfer may be recommended. If transfer is recommended or requested, you will be informed of risks, benefits, and alternatives. You will not be transferred until the other institution agrees to accept you;
- To expect a quick response to reports of pain;
- Know about the Wellness Center rules that affect you and your treatment;
- Voice any concerns or complaints with the Wellness Center to (302) 271-2522;

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YOU HAVE THE RESPONSIBILITY TO:

- Medical appointments for the Wellness Center can only be scheduled by referral from the School Nurse;
- Students with appointments must always report to class for attendance, teacher permission, and teacher signature on pass or agenda book;
- Students are responsible for informing the Wellness Center in advance if they need to cancel an appointment;
- Provide to the best of your ability, information about your illnesses, hospitalizations, medications, and other matters relating to your health;
- Ask questions when you do not understand information or instructions;
- Be considerate of the property and rights of other patients, staff and the Wellness Center;
- Follow Wellness Center rules and regulations developed to assure rights of all patients;
- Recognize the effect of your actions on your personal health;
- Respect the confidentiality of other patients;
- To inform the Wellness Center as soon as you believe that any rights have been violated.

We have read and understand the "Rights To and Responsibility To"

______________________________________ ______________________________________

Student Signature **Date** **Parent Signature** **Date**