

**CHRISTIANA CARE VISITING NURSE ASSOCIATION (CC VNA)
HIGH SCHOOL WELLNESS CENTERS
PARENTAL CONSENT FOR TREATMENT FORM**

_____, give my consent for _____
(Parent/Guardian name) (Student's name)

To receive services administered by CC VNA High School Wellness Centers

PHYSICAL HEALTH

- Assessment, diagnosis and treatment of minor illness and injury (may include a urinalysis, throat culture dispensing non prescription medication and/or providing prescription medication)
- Identification and referral for treatment, to students primary care provider for conditions such as high blood pressure, diabetes, and asthma
- Athletic, employment, routine and college physicals (may include a urinalysis and vision screen)
- Immunizations (Tetanus, Hepatitis B vaccine, etc) and routine tuberculin screening (PPD)
- Assistance in linking to medical provider, dentist or health insurance
- Coordinating services with student's Primary Care Provider as needed
- May include diagnosis, treatment, and prevention of communicable diseases
- Health and sexuality counseling, education, treatment and referral

EMOTIONAL HEALTH

- Individual, family and/or group counseling, crisis intervention, and referrals if indicated
- Drug, alcohol and substance abuse counseling and/ or referral

NUTRITION

- Sports Nutrition
- Weight management and healthy eating
- Nutrition counseling

EDUCATION

- Individual and/or group education
- Anger and/or stress management
- Smoking prevention and cessation
- Preventive education on teen risks/concerns
- Responsible decision making

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

THE WELLNESS CENTER DOES NOT PROVIDE THE FOLLOWING SERVICES: Distribution or prescribing birth control, hospitalization, x-rays, or act as the primary provider for complex medical or psychiatric conditions

BY SIGNING THIS CONSENT, I UNDERSTAND AND AGREE WITH THE FOLLOWING:

- Health information related to sports/school physicals and immunizations may be shared between the school nurse, athletic trainer and the Wellness Center staff
- Visits to the Wellness Center will be strictly confidential
- Consent may be withdrawn at any time by the parent/guardian
- All information requested on the Registration/Health History Form is accurate and complete
- Most services are provided at no cost
- I have read and completed this consent form
- I have had the opportunity to receive and review the Wellness Center Notice of Privacy Practices brochure
- I give permission for the Wellness Center to administer a Student Satisfaction Survey

Signature of Parent/Legal Guardian (Relationship) (Date) Signature of Student (Date)

Christiana 302-454-5421
Dover 302-672-1586
Glasgow 302-369-1501

Lake Forest 302-284-3800
Newark 302-369-1606
Polytech 302-697-8402

Sussex Tech 302-856-4360

**CHRISTIANA CARE VISITING NURSE ASSOCIATION (CC/VNA)
HIGH SCHOOL WELLNESS CENTER
REGISTRATION/HEALTH HISTORY FORM**

Do you have any worries or questions about your teen's physical or emotional health? Yes _____ No _____
If so, what are they? _____

Has your teen seen a medical provider in the last year? If so, how many times and why? _____

Has your teen ever been hospitalized for more than one day or had surgery? Yes ____ No ____ If yes,
When? _____ Which hospital? _____ Reason _____

Has your teen used an emergency room in the last year? Yes ____ No ____ If yes, how many times _____
Why? _____

Please list any medications your teen currently takes _____

Has your teen ever been excluded from sport participation? If yes, Why _____

Please circle any of the following illnesses or problems that your teen has ever had:

- | | | | | |
|--------------------|-------------------|----------------|-----------------|--------------------------|
| Asthma | Anemia | Arthritis | Thyroid | Rheumatic Heart Disease |
| Sickle Cell Anemia | Kidney Disease | Convulsions | Heart murmur | High Blood Pressure |
| Chicken Pox | Mumps | Measles | Seizures | Colitis/Stomach Problems |
| Fainting Spells | Tuberculosis | Diabetes | Hemophilia | Ear Infections |
| Attempted Suicide | Head Injury | Heart Problems | Sleep Problems | Frequent Headaches |
| Depression | Anxiety | Ulcers | Frequent Colds | Skin Problems |
| Mood Changes | Personal Hygiene | Anger | Eating Problems | Drug/Alcohol |
| Menstrual Problems | Appears Withdrawn | Smoking | Other _____ | |

Explanation: _____

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 the appropriate illness:

- | | | |
|----------------------------|------------------------|--------------------------------|
| _____ High Blood Pressure | _____ Diabetes (sugar) | _____ Stroke |
| _____ Heart Disease/Attack | _____ Thyroid Disease | _____ Asthma |
| _____ Kidney Disease | _____ Sickle Cell | _____ Tuberculosis |
| _____ High Cholesterol | _____ Mental Illness | _____ Cancer (Type/Site) _____ |

The above information is accurate and complete:

Signature of Parent/Legal Guardian (relationship to student) _____ Date _____

What is your regular source of payment for medical care? Please circle.

- | | |
|------------|---------------------------|
| Commercial | Delaware Healthy Children |
| Medicaid | No Insurance |
| Self Pay | Other/unknown |

Insurance information will be use only in case of an emergency.

Name of Insurance Company _____

Policy Number _____ Group Number _____

Subscriber _____ Relationship to Student _____

Medical Assistance Number (if applicable) _____

Prescription Plan _____ Yes _____ No _____