DEPARTMENT OF HEALTH AND HUMAN SERVICES
School Based Health and Wellness Centers

Enrollment Form

SCHOOL:_____ **Student ID #**

Student's Name_____ Home School_____Grade_____

Date of Birth_____Social Security # _ _ _ - _ _ - _ _ _ _ Gender ____Race/Ethnicity_____

Address _____ Home Phone_____

City _____State _____Zip Code_____Student Phone_____

Country of Birth _____Primary Language spoken at home _____

Student's Primary Health Care Provider_____Phone_____

Parent/Guardian _____ Date of Birth_____ Phone #_____

Other Emergency Contact_____ Contact's Phone # _____

Contact's Relationship to Child_____

I give permission for my child, _____, to enroll in the School Based Health/Wellness Center (SBHWC). I consent to his/her receiving services which may include complete physical examinations, immunizations, treatment for chronic and acute health problems, health screenings, limited laboratory and diagnostic tests, administration/prescribing of medications, health education, case management and /or referrals to mental health and social services. I give permission for SBHWC health and mental health professionals and School Health Services staff to share information or records as needed to provide appropriate services to my child through the SBHWC and support my child's success in school.

- The parent/guardian may or may not be present at the time services are provided, but will be notified by phone or in writing when a child receives services in the School Based Health/Wellness Center (SBHWC).
- All SBHWC records are confidential and only the SBHWC staff and providers will have access to a child's SBHWC records and information, unless the parent/guardian gives written consent, or the minor patient gives written consent, in the event the minor is receiving treatment for which the minor has the authority to consent.
- I understand that at this time, Maryland law does not require parental consent or notification for the following services provided by the SBHWC: treatment or advice about drug abuse, alcoholism, sexually transmitted infections, pregnancy or contraception to minors under 18 years of age, and mental health services to minors age 16 years or older.
- Services at the SBHWC will be provided by staff employed by or contractors with Montgomery County Department of Health and Human Services.
- If your child has health insurance through an insurance company that participates with Montgomery County, the insurer will be billed for services given in the SBHWC and the insurer may be provided required information about the child's health status or other information necessary to process insurance claims.
- If your child has health insurance through an insurance company that does not participate with Montgomery County or is uninsured, you will be billed for services given in the SBHWC based on a sliding scale. No fees will be collected at school.
- If your child is not insured please indicate on your enrollment form and you will be contacted by SBHWC staff to assist you in applying for Maryland Children's Health Program (HealthChoice) or Care for Kids coverage.
- I authorize payment of the medical benefits to Montgomery County for services rendered in the SBHWC.
- All enrolled children will be seen regardless of the family's ability to pay or insurance status.

I understand the description of services and policies of the SBHWC as stated above and give permission for my child to enroll and receive services in the SBHWC. I understand that this permission can be withdrawn at any time by submitting notice in writing.

Signature of Parent/Legal Guardian_____Date_____
Print Name _____ Relationship to Student_____