School-Based Wellness Center @ McCullough Middle School
20 Chase Ave
New Castle, DE 19720
302.429.4007

Dear Parents/Guardians**:**

The School-Based Wellness Center (SBWC) is a partnership between Nemours Children's Health, the Colonial School District, and the School-Based Health Alliance. Health care is provided in the SBWC at your child's school by a Nurse Practitioner and a Behavioral Health Therapist. This letter is an invitation to sign up your child in the SBWC.

To sign up your child in the SBWC, you need to provide the following:

- **Up-to-date insurance information** is needed if your child is insured. (Note: No co-pay, co-insurance or deductible will be charged to you and no one will be turned away based on ability topay).
- **A completed Consent Form** (included in this packet).
- A completed **Student Registration Form** (included in this packet) The completed enrollment/registration forms should be returned to the SBWC as soon aspossible.

SBWC services offered:

- Physicals
- Health screenings
- Immunizations
- Diagnosis and treatment of minor illnesses and injuries
- Counseling (individual, family, and group)
- Crisis intervention and suicide prevention
- Health education/risk reduction

Elective Services offered to patients age 12 and older:

- STI Testing
- HIV Testing
- Pregnancy Screenings
- Birth Control Pills
- Condoms
- Xulane Patch
- Nexplanon
- NuvaRing
- Depo-Provera
- Reproductive education and counseling

Nemours does not provide Intrauterine Devices (IUDs)

CONFIDENTIALITY

Some services offered by this SBWC are confidential by law. If you consent to your child receiving confidential services at the SBWC, then, according to Delaware Law (Title 13 §710), you will not have access to information about these services unless your child gives the SBWC permission to share that information. This includes the following information: Pregnancy testing, Diagnosis and treatment of sexually transmitted infections, Reproductive health services including contraceptive implant -- unless complications occur, and HIV testing.

Please know that your child's pediatrician or family doctor will still be your child's main doctor. The SBWC does not take their place, and we will work with your child's main doctor to care for your child. The SBWC offers services that may add to the care provided by your main doctor. When appropriate, and with your permission, we will try to share medical information with your child's doctor to prevent any duplication of health care services, and to take good care of your child. If your child does not have a doctor, we can help you find one.

We hope that you will register your child in the SBWC. Then, together with you and your child's main doctor, we can work towards keeping your child healthy and in school. Please encourage your child's pediatrician or family doctor to call the SBWC with questions. **If you have questions or need more information, please call the School-Based Wellness Center.**

Sincerely,

Denise Hughes
Program Manager, School Initiatives
(302) 332-2642

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

200001

SCHOOL-BASED HEALTH CENTER PARENT/STUDENT CONSENT FOR SERVICES

I _____, give my consent for _____

(Parent/Personal Representative of Student) **(Name of Student)**

to receive health services at the School-Based Health Center administered by **Nemours Children's Health (Nemours).**

Services Provided:

- Comprehensive health assessments (for students without a primary care physician)
- Immunizations
- Diagnosis and treatment of minor, acute and chronic medical conditions
- Referrals to and follow up for specialty care, oral and vision health services
- Behavioral Health, counseling, and treatment
- Referral to behavioral/mental health services including emergency psychiatric care, community and support program

Elective Services offered to patients age 12 and older (Please check the ones you agree your student may receive):

- ☐ **STI Testing**
- ☐ **HIV Testing**
- ☐ **Pregnancy Screenings**
- ☐ **Birth Control Pills**
- ☐ **Condoms**
- ☐ **Xulane Patch**
- ☐ **Nexplanon**
- ☐ **NuvaRing**
- ☐ **Depo-Provera**
- ☐ **Reproductive education and counseling**

I agree that my student may receive the Elective Services, as listed above YES NO (Must circle one)

In consenting to permit my student to participate in the School-Based Health Center, I acknowledge and agree to the following:

1. I have had the opportunity to receive and review the Nemours Notice of Privacy Practices brochure which is included within the packet.
2. ***I understand*** that insurance may be billed for covered services, and I agree to provide insurance information before services are provided.
3. ***I understand*** that the School-Based Health Center shall not charge co-pays or any other out-of-pocket fees for use of its services.
4. ***I understand*** that some elective services offered by this School-Based Health Center for students age 12 or older are confidential by law. I understand that, if I consent to my student receiving confidential services at the School-Based Health Center, Delaware Law (Title 13 §710) states that I will not have access to information about these services unless my student gives the School-Based Health Center permission to share that information. This includes the following information:
    - Pregnancy testing
    - Diagnosis and treatment of sexually transmitted infections
    - Reproductive health services including contraceptive implant -- unless complications occur
    - HIV testing

SCHOOL-BASED HEALTH CENTER PARENT/STUDENT CONSENT FOR SERVICES

5. ***I understand*** this consent may be revoked in writing at any time, except for any action already taken, prior to revoking this consent. The revocation must be in writing and sent to the School-Based Health Center associated with my student's care.
6. ***I understand*** the School-Based Health Center works in collaboration with Colonial School District. As a part of this
7. collaboration both parties can review and share all written and verbal information concerning my child on a need-to-know basis, including school and medical records. They can also discuss pertinent medical, behavioral, and/or social needs with Colonial School staff in the best interest of the child and family.
8. ***I understand*** that information, including recordings (photographs, video, electronic or audio media), may be collected, used and shared with others only as necessary for:
    - Coordinating treatment with healthcare providers;
    - Ensuring providers we refer you to have all the necessary health information;
    - Eligibility, billing, claims management, medical necessity, and utilization review;
    - Required reporting of diseases or injuries such as communicable diseases;
    - Required reporting to registries such as cancer and immunization; and
    - Inclusion in Health Information Exchanges.
9. ***I agree***, that school staff can accompany my child for a medical exam.
10. ***I agree*** that all information provided on the registration Health History Form and this consent is accurate and complete.
11. Telehealth
    - I understand that "telehealth" is the mode of delivering health care services using digital communication technology to help evaluate, diagnose, consult, educate, monitor, and manage care and treatment without being in the same physical location as my provider.
    - I understand that a telehealth visit is not the same as an in-person visit because I will not be in the same room with my provider. I understand that I will not be treated through telehealth unless my condition supports the use of this technology as my provider will not be able to perform some aspects of a full physical examination.
    - I understand that digital communication technology may include, but not be limited to real time two-way audio, video, or other telecommunications or electronic communications, including remote patient monitoring, secure video conferencing, and/or secure texting with my care team.
    - I understand that there are benefits to utilizing telehealth services, which include, but are not limited to, convenient medical evaluation and management. I also understand that there are risks involved in receiving treatment through telehealth, which include, but are not limited to interruption in the audio/video connection that may result in the visit being postponed until a later time and/or performed through an alternate method, and, in rare cases, unauthorized access to my confidential information. In the event of a technical failure, I understand that I should immediately contact my provider's office, or, if it is an emergency, dial 911.
    - I understand that laws protecting the confidentiality of my medical information also apply to telehealth and that Nemours uses security protocols to help protect my privacy and ensure my confidential communications are sent only to the intended care team member(s).
    - I understand that Nemours will not record the video or audio of my telehealth visit without my consent at the time of the recording.

SCHOOL-BASED HEALTH CENTER PARENT/STUDENT CONSENT FOR SERVICES

- I consent to have Nemours obtain health information from me and provide health care services to me through telehealth communications when and where my provider or qualified member of my care team determines it is appropriate and necessary.
- I understand that I may refuse or stop participation in telehealth services and request alternate services, such as an in-person visit, at any time.

12. My student and I have read this consent carefully. All my questions, if any, have been answered to my satisfaction. I understand that I may call the School-Based Health Center Coordinator if I have any questions before or after I sign this Consent for Services.

By signing below, I certify that I am the parent or legal representative of the student named above and have read the above consent statements about services offered at my student's School-Based Health Center and voluntarily agree to have my student participate. I acknowledge that I have been given no guarantee or assurance as to the results that may be obtained from the services/treatment.

Signature of Parent/Legal Representative:_____

Print Name of Parent/Legal Representative: _____

Relationship to Patient: _____ **Date:**_____**Time:**_____**(AM/PM)**

*Nemours Children's includes: The Nemours Foundation, a Florida not-for-profit corporation, its operating divisions and sites, and its affiliates and subsidiaries, including Nemours Children's Hospital, Delaware; Nemours Children's Hospital, Florida; Nemours Children's Hospital, Surgery Center, Deptford; Nemours Children's Hospital, Surgery Center, Malvern; and all entities operating under the name Nemours Children's Health.

NEMOURS CHILDREN'S HEALTH

Patient Name:
MRN:
DOB:

School-Based Health Center Patient Registration Form

School: **McCullough Middle School**					
Grade: 6 7 8				**Student ID (lunch) number:**	
Patient's Last Name:		**First:**		**Middle:**	
Identified Sex:	**Male**	**Female**	**Transgender Male**	**Transgender Female**	**Decline to Answer**
Address: **City:**		**State:**	**Zip Code:**	**Birthdate:**	
Language (Circle one)	English	Spanish	Sign	French	Other
Speak English?	Not at al	Not well	Well	Very well	Refused
Nemours Patient (Circle one): Yes No **Interpreter Needed (Circle one):** Yes No					
Ethnicity (Circle one):	Puerto Rican	Mexican, Mexican American, Chicano/a	Cuban Origin		
	Non-Hispanic or Latinc	Another Hispanic, Latino, or Spanish	Refused		
Race (Circle one):	American Indian or Alaska Native	Asian Indian	Black or African American	Chinese	
	Filipino	Guamanian or Chamorro	Japanese	Korean	
	Native Hawaiian	Samoan	White or Caucasian	Vietnamese	
	Other Asian	Other Pacific Islander	Other	Refused	
Parent 1 Full Legal Name:			**Date of Birth:**	Home Phone#:	
Address:			Cell Phone#:		
City:	State:	Zip Code:	Work Phone#:		
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody					
Parent 2 Full Legal Name:			**Date of Birth:**	Home Phone#:	
Address:			Cell Phone#:		
City:	State:	Zip Code:	Work Phone#:		
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody					
Legal Representative Name (if not mother or father): **Relationship to Student:**			**Date of Birth:**	Home Phone#:	
Address:			Cell Phone#:		
City:	State:	Zip Code:	Work Phone#:		
Do you have legal custody of the patient (Check one)? □ Full custody □ Shared custody □ Does not have custody					
If you are not available, is there another person we can contact to make decisions?					
Contact 1 Name:			Contact 1 Phone #:		
Contact 2 Name:			Contact 2 Phone #:		
Contact 3 Name:			Contact 3 Phone #:		

Insurance Information	
Insurance Name:	Member ID:
Subscriber	

Send in a Copy or take a picture and email Front and Back of Insurance Card to (SBHC@nemours.org)

Help us improve your care.

Patient's Name:_____Date of Birth:_____Today's Date:_____

At Nemours Children's Health, we want to provide the best possible care for your child and your family. Many things in your life can impact your child's health, like what you eat, how difficult it may be to get here, your job, and whether you are able to pay for medicine or medical treatment. With these questions, we are learning how we can better serve children and families. These questions may be personal, but like all your medical records, anything you share will be kept private and confidential. We are required by law to report any abuse. **Would you like to complete the form?** ❑Yes ❑No

1. In the past 6 months, were there times when you didn't have money to buy enough food? ❑Yes ❑No
2. In the past 6 months, have you ever had trouble paying for a doctor, dentist or medicine for you or your child? ❑Yes ❑No
3. In the past 6 months, has your utility company ever shut off your service because you could not pay your bill (electric, gas, water, heat, or phone)? ❑Yes ❑No
4. In the past 6 months, have you or your child ever had to stay in a shelter, stay with others, in a hotel, live outside on the street or somewhere else, even for one night? ❑Yes ❑No
5. Currently, do you have any problems in the place where you live like mold, bugs, ants or mice; lead paint or pipes; lack of heat or air conditioning; lack of smoke detectors, oven or stove; water leaks or other repair issues? ❑Yes ❑No
6. Are you concerned about losing your housing? ❑Yes ❑No
7. In the past 6 months, have you or any other family member been hit, threatened, abused, or bullied? ❑Yes ❑No
8. In the past 6 months, did your child ever go without medicine or miss a medical appointment because you didn't have a way to get to the pharmacy or doctor's appointment? ❑Yes ❑No

Are you interested in receiving assistance from Nemours Children's staff or information about other professional resources on how to meet these needs? ❑Yes ❑No

NEMOURS CHILDREN'S HEALTH

For more information, visit Nemours.org.
Well Beyond Medicine

Child ID#: _____ Child age _____

Caregiver: _____ Date: _____

Pediatric Symptom Checklist-17 (PSC-17)

INSTRUCTIONS*:* Emotional and physical health go together in children. Because caregivers are often the first to notice a problem with their child's behavior, emotions or learning, you may help your child get the best care possible by answering these questions. Please mark under the heading that best fits your child.

	Please mark under the heading that best fits your child			***For Office Use***		
Does your child:	**Never**	**Sometimes**	**Often**	**I**	**A**	**E**
1. Feel sad.	☐	☐	☐			
2. Feel hopeless.	☐	☐	☐			
3. Feel down on him/herself.	☐	☐	☐			
4. Worry a lot.	☐	☐	☐			
5. Seem to be having less fun.	☐	☐	☐			
6. Fidget, is unable to sit still.	☐	☐	☐			
7. Daydream too much.	☐	☐	☐			
8. Distract easily.	☐	☐	☐			
9. Have trouble concentrating.	☐	☐	☐			
10. Act as if driven by a motor.	☐	☐	☐			
11. Fight with other children.	☐	☐	☐			
12. Not listen to rules.	☐	☐	☐			
13. Not understand other people's feelings.	☐	☐	☐			
14. Tease others.	☐	☐	☐			
15. Blame others for his/her troubles.	☐	☐	☐			
16. Refuse to share.	☐	☐	☐			
17. Take things that do not belong to him her.	☐	☐	☐			
TOTAL						

To Score:

Fill in the unshaded box on the right: "Never" = 0, "Sometimes" = 1, "Often" = 2.

Sum the columns.

PSC17-Internalizing score is the sum of column I.

PSC17-Attention is the sum of column A

PSC17-Externalizing is the sum of column E.

PSC-17 Total Score is the sum of PSC17-I + PSC17-A + PSC17-E.

Positive Scores:

PSC17-I	≥ 5
PSC17-A	≥ 7
PSC17-E	≥ 7
Total Score	≥ 15