Smyrna High School: Bayhealth Wellness Center

PH: 302-653-2399 Fax: 302-653-1342

Email: wellness@smyrna.k12.de.us

August 2024

Dear Students and Parents,

Summer is ending and we are gearing up for a new school year. The staff at the Bayhealth Wellness Center at Smyrna High School hopes that you have had a safe and enjoyable summer. We look forward to serving the students of our community in the future.

Bayhealth's Wellness Centers provide Delaware's teenagers with health services in cooperation with each teen's family physician. The center provides medical services, mental health counseling, nutritional counseling and health education for its members. The goal of the Wellness Center is to promote healthy lifestyles, increase school attendance and improve the student's ability to concentrate. All students in grades 9-12 are eligible to access Wellness Center services.

To participate in the Wellness Center, a parental consent and teen health history form must be completed for each student, and can be returned via fax/e-mail. Forms are available on the Smyrna High School website under the Wellness Center tab (found under Academics & Programs tab). Paper copies are available at the High School in the Main office, Guidance office and in the Wellness Center.

The Division of Public Health has mandated that Wellness Centers submit claims to insurance companies. Parents and students however, **will not** be expected to pay traditional copays or be billed for any services rendered at the Wellness Center. No one is denied services based on insurance or ability to pay. Insurance information is however required at the time of registration.

The mission of the Smyrna School District is to ensure that the students of the community are prepared as effectively and as efficiently as possible to become responsible and productive citizens possessing the knowledge, the problem-solving skills, and the positive attitudes necessary to successfully adapt to and function in an ever-changing environment. Our goal at the Wellness Center is to provide quality and compassionate health care to help further this mission.

The Wellness Center at Smyrna High School will be open on some Tuesdays throughout the summer, July 16th and 30th, August 5-6th and 12-13th for sports and/or new student physicals. Our Nurse Practitioner and Mental Health Provider are here for you. You can reach the Wellness Center by calling 302-653-2399; messages are checked weekly and returned. You can also email us at: wellness@smyrna.k12.de.us to set up an appointment. We look forward to serving you.

Sincerely,

The Wellness Center Staff

RESOURCES

Town of Smyrna Police 302-653-9217
Delaware Helpline 211
NEED A DOCTOR? 1-866-Bay-Docs

Mental Health Crisis

Mental Health Association 1-800-287-6423
CPR (0-17 yrs. old) 1-800-969-4357
Mobile Crisis (18+ yrs. Old) 1-800-345-6785
Contact Life Line/Rape Crisis 1-800-262-9800
Dover Behavioral Health 1-855-609-9711
Domestic Violence Hotline 1-800-701-0456

WELLNESS CENTER VS. SCHOOL NURSE

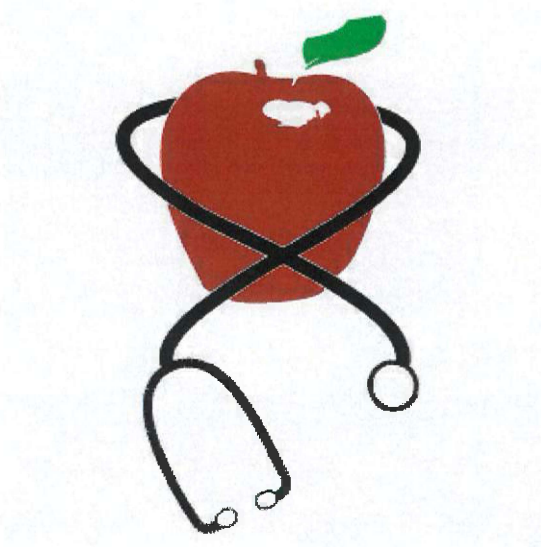
- One does not replace the other
- The school nurse is responsible for the day-to-day health of the entire school population
- School-based health clinics provide medical appointments and mental health counseling
- School nurse is a district employee
- Wellness Center staff are Bayhealth employees

The Smyrna High Wellness Center is partially funded through the State of Delaware Public Health and ***reimbursed from insurance*** for those students who have insurance. ***There is never a fee to the student. Students without Insurance are not denied.***

Smyrna High School
Stacy Cook, Principal
500 Duck Creek Parkway
Smyrna, DE 19977
(302) 653-8581

Smyrna High School Wellness Center

A *Bayhealth* school-based health center



Smyrna High School Wellness Center

130's Hallway

500 Duck Creek Parkway

Smyrna, DE 19977

Phone: 302-653-2399

Fax: 302-653-1342

Hours: 7:15am to 3pm*

***Limited hours during the summer**
***Staff may be available for other times by request**

About Us

The Smyrna High Wellness Center is a school-based health clinic. The Wellness Center is to:

- Provide Smyrna High School students with a means of obtaining health services that can be coordinated with each teen's family physician
- Reduce health-related absences
- Meet not only the physical needs of today's adolescent but also the health education, nutritional, mental and emotional needs
- Focus on prevention services with a goal of promoting positive physical and mental health

Students must have parental or legal guardian consent to use the services. The Wellness Center is staffed by a **Nurse Practitioner, a Mental Health counselor, a Registered Dietician and an Administrative Assistant.**

The services available at the Wellness Center were developed by Public Health, Smyrna School District, and a Wellness Center Advisory Council comprised of parents, students, faculty, and healthcare providers.

Bayhealth Wellness Center
Meeting the Needs of Today's Adolescents

Benefits

- Easier access to health care
- Early identification and treatment of minor illnesses
- Decrease in parental time away from work for medical appointments
- Decrease in student health related absences

Services

- Physical exams: routine, sports, camp and job
- Diagnosis and treatment of acute minor illnesses and injuries
- Health education of topics relevant to adolescents
- Evaluation and treatment of mental and emotional health needs
- Nutritional counseling
- PPD testing
- Immunizations in accordance with Division of Public Health
- Confidential reproductive health counseling, testing and services
- Sexual assault counseling provided by Contact Life Line

HEALTHY KIDS LEARN BETTER

Enrollment

All parents /legal guardians of Smyrna High School students are encouraged to enroll their students with the Wellness Center.

- **The Consent and Health History forms must be completed and returned to the Wellness Center before services can be provided**
- Forms are available in the main office and the Wellness Center. They can also be downloaded from: **www.smyrna.k12.de.us/Page/796**
- **Health insurance** information must be completed to register
- Students who are **18 years old** may enroll themselves

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THE DRIVE IS *here.*

Place Patient Label Here
Name & Date of Birth

SCHOOL-BASED WELLNESS CENTER

PARENT/STUDENT CONSENT FOR SERVICES

As a Parent or guardian of a **minor** child (less than 18 years) you can elect whether your child will receive services at the Wellness Center. Students 18 years or older may sign for themselves to receive these services. **(PLEASE PRINT IN INK)**

I, _____, give my consent for _____ to receive
(Name of Parent/Legal Guardian of Student) **(Name of Student)**

health services at the _____ Wellness Center Administered by Bayhealth Medical Center.
(Name of the School)

Wellness Center services include the following, as needed or requested;

PHYSICAL HEALTH

- Assessment, diagnosis and treatment of minor illness and injury
- Physical examinations, including sports/employment/college physicals
- Immunizations in accordance with the Division of Public Health
- Nutrition services and referrals

COUNSELING

- Individual, Group or 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 following services are also available to students 12 years of age or older who are enrolled in this school-based Wellness Center. According to Delaware Law (Title 13 §710) a minor child 12 years of age and older can receive these confidential services without parental consent. This law applies to all medical facilities and providers. Information about confidential services can only be shared when your child gives the Wellness Center permission to do so or at the discretion of the health care provider having primary regard for the interests of the minor.

CONFIDENTIAL SERVICES

- Condoms, Hormonal Birth Control (e.g. Oral Contraceptives & Depo)
- Pregnancy testing
- Diagnosis and treatment of sexually transmitted diseases
- HIV Counseling and Testing

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

PLEASE COMPLETE OTHER SIDE

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THE DRIVE IS *here.*

SCHOOL-BASED WELLNESS CENTER

Place Patient Label Here
Name & Date of Birth

PARENT/STUDENT CONSENT FOR SERVICES

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. School-Based Wellness Centers are funded through state funds and reimbursement from insurance for those students who have insurance.

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: sexually transmitted disease, 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 your child's name will be removed. Information about services may be shared with your health insurance company for purposes of quality improvement.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT
BAYHEALTH SCHOOL BASED WELLNESS CENTERS

Effective April 14, 2003, the Wellness Center must comply with the Private 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 you that we have collected. 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. **You may contact the Wellness Center staff to obtain the most current copy.**

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.

By my signature below I agree, as the parent or legal guardian of the student named, or as an adult student that

- He/she may receive services at the School-Based Wellness Center **(the "Wellness Center")**
- This consent will remain in effect as long as my child is enrolled in this school
- This consent may 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.
- If my child has insurance I will provide this information to the Wellness Center.
- I understand that the Wellness Center will bill my insurance for covered services and it is my responsibility to be aware of the terms and limitations of my insurance coverage.

Signature of Parent/Legal Guardian	Date	Time
Print Name of Parent/Legal Guardian		
Signature of Student	Date	Time
Print Name of Student		

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School-Based Wellness Center-Registration & Health History

Patient Label

Services **will not** be provided unless all sections of this form are complete. **(PLEASE PRINT CLEARLY IN INK)**

Student Name: _____ **Birthdate** ___/_____/___ **Age:** _____

Address: _____
(Street) **(City)** **(State)** **(Zip)**

Student Phone: (Home) _____ (Cell) _____ **Grade:** _____

Gender: ☐ Male ☐ Female **Ethnicity:** ☐Hispanic or Latino ☐Not Hispanic or Latino **Student's Preferred Language:** ☐English ☐ Spanish ☐ Other please list_____

Race: Please check ✓all that apply
☐American Indian/Alaska Native
☐Asian
☐Black/African American
☐Native Hawaiian/Pacific Islander
☐White/Caucasian

Name of Student's Medical Provider (Doctor): _____

Address: _____ Phone: _____

☐ **NO PHYSICAN OR MEDICAL PROVIDER**

Name of parent/legal guardian: _____ Relationship to child__

Parent/guardian Phone: (Home) _____ **(Cell)** _____ **Email:** _____

INSURANCE INFORMATION IS REQUIRED TO PROCESS STUDENT VISITS AND A COPY OF YOUR INSURANCE CARD MUST BE PROVIDED

Please indicate your medical coverage. ☐ **NO MEDICAL COVERAGE**

☐ **PRIMARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: ___/___/___ Relationship to child: _____

☐ **Medicaid#** _____

☐ **SECONDARY MEDICAL INSURANCE**

Name of Insurance Company: _____

Insurance Address: _____

Student Policy #: _____ Group Number: _____

Subscriber Name: _____ Subscriber Birthdate: ___/___/___ Relationship to child: _____

☐ **Medicaid#** _____

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School-Based Wellness Center-Registration & Health History

Patient Label

A COMPLETE AND ACCURATE HEALTH HISTORY IS NEEDED IN ORDER FOR THE STAFF TO PROVIDE QUALITY HEALTH CARE.

ALLERGY HISTORY

☐ No Allergies
☐ Medication Allergy (please list): _____
Allergy to: ☐ Latex ☐ Peanuts ☐ Eggs ☐ Other (please list) _____

MEDICATIONS: Please list all medications child is currently taking: prescription, over the counter, herbal supplements

Name of medication	Dose	Reason for use

FAMILY HEALTH HISTORY-Please check ✓ and indicate which blood relative (i.e. parents, grandparents, siblings) have had the following:

☐ Asthma	☐ Anxiety	☐ Depression
☐ Diabetes	☐ Heart Disease/Attack	☐ High Blood Pressure
☐ Kidney Disease	☐ Sickle Cell	☐ Stroke
☐ High Cholesterol	☐ Blood Clots in legs/lungs	☐ Cancer
☐ Obesity	☐ Other:	

STUDENT HEALTH HISTORY

Please check ✓ any of the following conditions that your son/daughter has now or has had in the past.
Indicate with (P)-Past or (C)-Current. Please provide an explanation below for any **CURRENT** problem checked.

☐ ADD/ADHD	☐ Anemia	☐ Anxiety	☐ Asthma
☐ Cancer (type):	☐ Chicken Pox –year:	☐ Cholesterol (high)	☐ Clotting Disorder
☐ Concussion	☐ Depression	☐ Diabetes	☐ Eating Disorder
☐ Headache-Migraine	☐ Hearing Loss	☐ .Heart Murmur	☐ High Blood Pressure
☐ Overweight/Obesity	☐ Learning Disability	☐ Rashes/Skin problem	☐ Seizures
☐ Self-injurious Behavior	☐ Physical Limitations	☐ Suicide Attempts	☐ Smokes/Chew Tobacco
☐ Trauma/Violence	☐ Ulcer/Reflux	☐ Vision Problems	☐ Other:

Explanation of CURRENT illness or problems: _____

List all past surgeries:

Type of Surgery	Date
	Date / /
	Date / /

Do you have any worries or questions about your teen's physical or emotional health that you would like the Wellness staff to address? ☐ Yes ☐ No

If yes, what are your concerns? _____

Is your teen currently receiving counseling or mental health services: ☐ Yes ☐ No

Name of Counselor/Facility: _____

I have read this form carefully and ***I acknowledge*** that all information requested on the Registration & Health History Form is accurate and complete.

Signature of Parent/LegalGuardian: _____ Date: / /