Warrior Wellness Center Enrollment Form

Healthy Kids Learn Better

WARRIOR WELLNESS CENTER AT CHS
MarillacHealth

The Warrior Wellness Center (WWC) is a school-based health center (SBHC) inside of Central High School that provides in-school access to medical, behavioral health, and dental care. We work with the school nurse, health aide and counselors to provide quality care. Studies show students who use school-based health centers miss less school. Parents or guardians need to sign their student up for SBHC services. Student access may be removed at any time with written notice. Services are open to all students and staff of Central High School.

Students are allowed to attend appointments by themselves. Students will be sent home with a summary of their primary care visit if requested. It is our goal to encourage students to have their family involved in their care and we will try to facilitate this where possible.

Enrollment at the WWC may allow your student to be seen and billed for the following services:

Yearly medical check-up (may include routine lab tests)	Referral to other healthcare specialists
Sports physicals	Substance use prevention, education, and counseling
Care for common colds, other illnesses & injuries	Behavioral health services to include individual counseling visits
Prescriptions for bacterial illnesses and other medications	Healthy eating and exercise education
Assistance in the care of chronic conditions	Family planning education and counseling

Enrollment Information

Student First Name _____ Last Name _____ Date of Birth _____

Current Grade_____ Student Social Security Number _____ Student Phone Number_____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Parent/Guardian First Name _____ Last Name _____ Phone _____

Physical Address _____ City _____ State _____ Zip Code _____ _

*Below please put the address you receive mail at. If you do not have a mailing address, please check this box: ☐

Mailing Address _____ City _____ State _____ Zip Code _____

Email Address _____ Student Email Address_____

Does your child have a Primary Care Provider (Please check one): **YES** **NO** If yes, who: _____

RACE *(CIRCLE AT LEAST ONE)*		**PRIMARY LANGUAGE** *(CIRCLE AT LEAST ONE)*	**SEXUAL ORIENTATION** *(CIRCLE ONE)*	**ETHNICITY** *(CIRCLE ONE)*	**GENDER IDENTITY** *(CIRCLE ONE)*
BLACK OR AFRICAN AMERICAN		AMERICAN SIGN LANGUAGE	STRAIGHT	HISPANIC/LATINO ORIGIN	MALE
AMERICAN INDIAN OR ALASKA NATIVE		ENGLISH	BISEXUAL	NOT HISPANIC/LATINO ORIGIN	FEMALE
ASIAN		FRENCH	LESBIAN	NOT PROVIDED	GENDERQUEER/NONBINARY
WHITE		POLISH	GAY		TRANSGENDER WOMAN/ TRANSGENDER FEMALE
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	SOMETHING ELSE		TRANSGENDER MAN/ TRANSGENDER MALE
NOT PROVIDED		SPANISH	DO NOT KNOW		OTHER
		OTHER	CHOOSE NOT TO DISCLOSE		CHOOSE NOT TO DISCLOSE

Telehealth

Are you interested in receiving care for your child through a video call (Telehealth) _____ Yes _____ No

Vaccine Consent

We offer vaccines for students and staff. I consent for my student to receive vaccines at the School Based Health Center. Parent or guardian must approve of each vaccine prior to being given and this can be done via verbal consent over the phone.

Signature Required _____ Date_____

Healthy Smiles Program

School Based Health Center provides dental care. There will be no charge for the services listed below. Please mark what you would like your child to participate in.

- I give consent for my child to receive an oral health screening. ____Yes ____No
- I give consent for my child to receive fluoride varnish application. ____Yes ____No
- I give consent for my child to received dental sealants. ____Yes ____No

The below services are covered by dental insurance. If you do not have insurance, the below services will only be **$20.**

- I give consent for my child to receive dental cleaning. ____Yes ____No
- I give consent for my child to receive dental x-rays. ____Yes ____No

When was your child's last visit to a dentist?

____0-6 months ago ____6-12 months ago ____More than a year ago ____Never

Does your child have a Dental Home (Please CHECK): **YES** **NO** If yes, who: _____

Financial Arrangements

Students and staff may seek services at the Warrior Wellness Center. We will bill your insurance if that applies. The maximum out-of-pocket cost you will pay per visit is $20 and this includes:

- Yearly medical exam (Well Child Check)
- Sports physicals
- Vaccine visits
- All other medical visits
- Dental visits
- Behavioral health visits

Please provide your student's **Medical** Insurance type and Member ID:

___ Medicaid # _____

___ CHP+ ID #_____

___ Marillac Card

___ Uninsured (do not have health insurance)

___ Private Insurance Name_____ ID# _____

Group Number_____ Insured Subscriber _____

Date of Birth of Subscriber _____ Relationship to Subscriber_____

I have read, understand, and consent to the services offered by the Warrior Wellness Center. I understand that my child's attendance, vaccine records, basic information and school schedule may be shared between school and SBHC staff to provide quality care for my child. I hereby acknowledge that I have been offered a copy of the SBHC's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available on the Marillac Health web site: https://marillachealth.org/hipaapolicy/

I understand that the Colorado Department of Public Health and Environment (CDPHE) provides funding for the health services I receive at the School Based Health Center. CDPHE is legally able to receive information regarding services provided to patients. CDPHE receives combined data for all patients, and **this data does not identify any individual patient or patient identifying information.**

I authorize the Warrior Wellness Center to bill and receive payment from my insurance and to provide any portion of my child's medical record as necessary to bill and receive payment for services from my insurance company.

I/We agree to the SBHC enrollment requirements _____YES _____Please Initial

Signature: _____ Date: _____