To Parent(s) and/or Guardian(s):

Monroe Health Center will once again open our Wellness Centers for the upcoming school year. They are currently located at Mountain View Elementary/Middle School, Peterstown Elementary/Middle School and James Monroe High School.

The Wellness Center gives your child an opportunity to be seen by a licensed health care provider without having to miss a lot of school time. An explanation of services offered by the Wellness Center is listed below. You do not have to be present for your child to be seen however a consent form must be signed by you in order for any services to be rendered. Thanks and hope you have a happy & healthy school year!

Description of Services

- Preventative Medicine Services such as Well Child Physicals & Immunizations.
- Sports Physicals, Allergy Injections, Prescriptions, Lab Testing, Referrals & Follow-up Care.
- Care for Acute Illness, Minor Injuries & Chronic Conditions.
- Mental Health Counseling (example coping skills, stress/anger management, depression, anxiety).
- Family Planning Services including abstinence education, birth control and STD prevention

If you do not have insurance, there will be no cost for services. If you do have insurance, it will be billed when the child is seen. The co-pay and any deductible for students will be waived. If you have any questions or concerns please contact us at any of the following numbers.

Staff, Contact Information & Hours

Our staff is here to assist you and we are available to communicate with the parents of each child. We want to know your concerns and be able to keep you updated on your child's health. Feel free to contact us during office hours. The Wellness Center works with and does not replace, your family doctor and/or school nurse.
Our staff includes: Dr. Jennifer Bailey, DO, Medical Director; Keri Galford, PA; Elizabeth Wickline, PA; Katrina Shires, FNP; Candice Young FNP; Alicia Walker, Psychologist; Kevin Harper, LIC-SW; Emily Atkins LPN; Stephanie Darnell, LPN; Kim Rhodes, LPN

Mountain View Wellness Center
620 School Street
Union, WV 24983
Phone: (304) 772-4580
Fax: (877) 853-9233
Hours: Monday – Friday
8AM-4PM

Peterstown Wellness Center
5414 Ballard Red Sulphur Parkway
Peterstown, WV 24963
Phone: (304) 753-4336, Ext 400
Fax: (304) 936-0155
Hours: Monday – Friday
8AM-4PM

James Monroe Wellness Center
142 James Monroe Dr.
Lindside, WV 24951
Phone: (304) 753-5940
Fax: (877) 841-1061
Hours: Monday – Friday
8AM-4PM

After hour's number: 1-866-834-6531

ENROLLMENT & CONSENT FORM

_____ SCHOOL YEAR ; _____ TEACHER

STUDENT INFORMATION

Student Name: _____ Gender: M or F Date of Birth: _____ Grade: _____
Address: _____ City/State/Zip/County: _____
Student SS#: _____ Email: _____Cell:_____
Race: White, Black or Other _____ Ethnicity: Latino or Other _____ Language: English, Spanish or Other

PARENT / GUARDIAN INFORMATION/EMERGENCY CONTACT *please list in order contact preference*

#1)Name _____relationship_____ Phone (H) _____ (W) _____(C) _____
#2)Name _____relationship_____ Phone (H) _____ (W) _____(C) _____
#3)Name _____relationship_____ Phone (H) _____ (W) _____(C) _____
Are there any custody documents related to this child yes or no? *** If so a copy is required for our records.

HEALTH INFORMATION

1. List any allergies your child may have and any medications your child should not take: _____
2. List any medications your child currently takes and why: _____
3. Family Physician/Pediatrician: _____ or None Dentist: _____
4. If we need to call in a prescription, which pharmacy would you like us to call? _____
5. Please initial if you would like your child to have a Well Child Exam at the Wellness Center:_____
6. Medical History _____, Surgical History _____
7. Hospitalizations_____, Special Needs _____

INSURANCE - Please provide a copy of your current Insurance Card if not available fill out information below

☐ INSURANCE: Name of Insurance Company: _____
Please fill out Information or Provide copy of Card front & back
Address: _____
City/State/Zip Code: _____ Insurance Phone #: _____
Policy/ID #: _____ Group #: _____
Policy Holder Name: _____ Date of Birth: _____
Policy Holder SSN#: _____ Place of Employment: _____

☐ MEDICAID: Please Check One ☐ Unisys ☐ Unicare ☐ Carelink
ID#_____ Group #_____

☐ WV CHIPS: ID#_____

☐ No Health Insurance/Request Application for Sliding Scale Fee/CHIPS/Medicaid
Gross Monthly Income: _____ Number in Household: _____

Please See Other Side

Student's name: _____

CONSENT FOR WELLNESS CENTER SERVICES

I, the parent/guardian of said student, give consent for my child to receive all services at the Wellness Center. I understand that this consent form is valid for the entire school year while my child is enrolled or until I provide the Wellness Center staff with written directions otherwise.

All healthcare information is confidential. By signing the consent form you are giving the Wellness Center, school nurse and your child's regular doctor (if applicable) permission to communicate and share medical information regarding your child's medical condition on an as needed basis with the understanding that this information will continue to be treated in a confidential manner. No student will be denied access to health care services due to inability to pay. As in any health center, there may be a charge depending on the service provided. When available, insurance or Medicaid will be billed. The health center may release information regarding treatment to third party payers for billing purposes.

Confidentiality between the student, parents and the health center is assured. By law, some information requires the student's signed consent prior to disclosure to anyone, including parents/guardians. The staff will encourage every student to involve his/her parent/guardian in health care decisions. I am the legal guardian of the above named child. I understand that if guardianship changes a new consent must be signed by the legal guardian. I also understand that by providing an alternative contact, if I cannot be reached, medical information regarding the above named child will be shared between the medical provider and the alternative contact

_____ _____ _____

Signature of Parent / Legal Guardian Staff Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires all physicians and health care facilities to provide patients with a notice describing how an individual's medical information may be used and disclosed, and how a patient may obtain access to their personal health information.

Please note that a copy of this policy is located at the Wellness Center, can be obtained from our sponsoring center's web site www.monroehealthcenters.com or can be mailed to you at your request. You must sign below, indicating that you have received notification on how to obtain a copy of our HIPAA policies, prior to the student receiving services.

_____ _____

Signature of Parent/Guardian Date

_____ _____Signature of Staff

Date

Please see other side