

Howard High School Wellness Center

576-8080

Overview of Wellness Centers

There are wellness centers in almost every high school in the state. They are all funded by a Delaware Department of Public Health grant. Several different organizations manage these grants. At Howard we are managed by Christiana Care. We are all designed to function separately from the school yet cooperatively with the school. As a result, our records are confidential. We are required to have an Advisory Council that meets about 3 times a year. Any one who is interested in joining please let us know. Here at Howard, we are staffed in a similar manner to all school wellness centers. All centers have a medical provider, social worker, administrative assistant, dietician, and physician. Each position has a minimum required amount of hours a week which varies depending on the profession/role of the position.

Purpose of Wellness Centers

During the teen years it is often difficult for students to get the medical care they need. High school students are very busy with school, extra curricular activities and work. They are unable to miss school to make appointments, and parents are often unable to miss work. Your student can get many medical needs met in the Howard High School Wellness Center, and our services are **free**. We do not take the place of a student's primary doctor and will communicate with the doctor when the student is willing for us to do so. We usually schedule appointments during SHOP class but are also available during lunch and before and after school.

Location

We are located in Howard High School. We are on the East side of the main building on the hall just past the Guidance office. We are just next to the School Nurses' office.

Services

Only Howard students who register may receive our services, and all services are **FREE**. We have on our staff nurse practitioners, a medical doctor, a licensed clinical social worker (counselor), a registered dietitian and an administrative assistant. We provide routine services such as sports physicals and immunizations. We treat sick students, so they don't miss as much school. Our medical providers are able to give out some basic prescription and over the counter medication we have available. We provide counseling for everyday teen problems and more serious mental health problems. We provide nutrition education for athletes and those wishing to make changes in their weight. We also provide testing, treatment, education and referral for sexually transmitted diseases and pregnancy. The choice in restricting any of our services belongs to the parent. Feel free to cross out any of the services you do not want your child to receive. Students are also allowed to decline any service they do not want by telling us.

PHYSICAL HEALTH

- Assessment, diagnosis and treatment of minor illness and injury.
- Identification of conditions such as high blood pressure, diabetes, asthma and coordination with student's medical home
- Athletic, employment, routine and college physicals (may include a urinalysis)
- Immunizations and routine tuberculin screening (PPD)
- Assistance in linking to medical provider, dentist or health insurance
- Gynecological services (may include PAP smear and pregnancy testing)
- Diagnosis and treatment of sexually transmitted diseases (includes STD cultures)
- Counseling for family planning methods including the benefits of abstinence and linking to family planning community services

EMOTIONAL HEALTH

- Individual, family and group counseling
- Drug, alcohol and other substance abuse counseling and link to outside provider when need identified
- Connect to long term counseling if need identified
- Crisis intervention (such as suicidal or homicidal thoughts)
- Anger/stress management
- Smoking prevention and cessation

NUTRITION COUNSELING

- Sports nutrition
- Weight management and healthy eating
- Prenatal and Postpartum nutritional counseling
- Specialized diets

Confidentiality

Although we work closely with the school nurses and have an office next door, our services and charts are separate from the school. We only release information about students as required by law or when the student gives us permission to do so.

Enrolling

To be seen in the Wellness Center all students under 18 must be enrolled by their parent/guardian. Parents must complete and sign the Consent Form and the Registration Form. This only has to be done one time and the student will be enrolled until graduation. A parent may revoke a student's enrollment at any time or refuse certain services by scratching them off on the Consent Form. There is no cost to enrolling or to any other service we provide.

Scheduling

All a student has to do to schedule an appointment is to stop by or call us at 576-8080. A parent may also call and request that we schedule their student. We mainly schedule appointments during SHOP, or Quest and Rotation for freshman. We can schedule appointments on a limited basis during other non-academic classes also. We are often here just before and after school hours for those students who are able to be seen during those times.

Services for All Students

We also provide general educational events for all students. Our topics usually involve general health or prevention of teen risk behaviors. We have an informational table in the cafeteria approximately once a month on various topics. We also have a free lunch and learn about once a month that is open to all students who sign up (space is limited). If a teacher requests us to come do a presentation for their class we will do that as well. We have brochures about various issues and local services available to all students in our office.

Questions

If you have further questions please call us at 576-8080. We are open during school hours/days, usually from 8:00 AM to 4:00 PM. We are opened on a very limited basis during the summer holiday. You may also e-mail the Wellness Center manager, Leighanne Hollans, at lhollans@christianacare.org

Forms

Parental Consent Form (*See attached*)

Registration/Health History Form (*See attached*)

Delaware Interscholastic Athletic Association Form (for sports physicals)
http://www.doe.k12.de.us/infosuites/Students_family/diaa/files/diaa_physicaleval.pdf

Delaware Department of Public Health Adolescent Programs
<http://dhss.delaware.gov/dhss/dph/chca/dphahinfo01.html>

Where do you take your child when they are sick? (i.e. primary doctor, emergency room, clinic): _____

Who is your child's primary doctor:

Name: _____

Telephone #: _____

Address: _____

Fax #: _____

Has your child been seen by a health care provider in the past year? Yes No

If yes, please indicate the number of visits: _____

Reason(s) for visit(s): _____

Has your child been seen in an emergency room within the last year? Yes No

If yes, please indicate the number of visits: _____

Reason(s) for visit(s): _____

Has your child been seen for a dental visit in the last year? Yes No

Name of Dentist: _____

Has your child had an eye exam in the last year? Yes No

Name of Eye Doctor: _____

Has your child received a Tetanus Booster (TD, DTP, or Tdap) within the last 10 years? Yes No

Date: _____

Has your child received the Hepatitis B series? Yes No

1st Date: _____ 2nd Date: _____ 3rd Date: _____

Has your child received the Chicken Pox Vaccine? Yes No If yes, list date: _____

Has your child ever had Chicken Pox? Yes No If yes, list date: _____

Has your child ever been hospitalized for more than one day and/or had any surgery? Yes No

If yes, when? _____ What hospital? _____

Reason: _____

Has your child ever received counseling or been hospitalized for emotional health? Yes No

If yes, when? _____ Where? _____

Reason: _____

Please indicate which of the following your **CHILD** has ever had:

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Sleeping Problems |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Attempted Suicide |
| <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Asthma | <input type="checkbox"/> Sports Injury | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Anemia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach/Intestinal Problems | <input type="checkbox"/> Sickle Cell | <input type="checkbox"/> Other_____ |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney/Bladder Disease | <input type="checkbox"/> Hemophilia | |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Cancer | <input type="checkbox"/> Depression | |

If any of the above is checked, please give more detail. _____

Please list any regular prescription, over-the-counter or alternative medication your child takes: _____

Does your child have any **ALLERGIES?** (medication, food, environmental or latex) Yes No

If yes, please list _____

Does your child use an EpiPen for allergic reactions? Yes No

Please indicate your preferred pharmacy _____ Telephone # _____

Please check any of the following illnesses that your **FAMILY MEMBERS** (parent, brother, sister, grandparent, aunt, uncle, etc.) have ever had and indicate which family member next to the illness:

- | | | |
|---|--|--|
| <input type="checkbox"/> Seizures_____ | <input type="checkbox"/> High Blood Pressure_____ | <input type="checkbox"/> Arthritis_____ |
| <input type="checkbox"/> Headaches_____ | <input type="checkbox"/> High Cholesterol_____ | <input type="checkbox"/> Tuberculosis_____ |
| <input type="checkbox"/> Deafness_____ | <input type="checkbox"/> Asthma_____ | <input type="checkbox"/> Hepatitis_____ |
| <input type="checkbox"/> Thyroid Disease_____ | <input type="checkbox"/> Cystic Fibrosis_____ | <input type="checkbox"/> Anemia_____ |
| <input type="checkbox"/> Diabetes_____ | <input type="checkbox"/> Unexplained Death_____ | <input type="checkbox"/> Sickle Cell_____ |
| <input type="checkbox"/> Stroke_____ | <input type="checkbox"/> Kidney/Bladder Disease_____ | <input type="checkbox"/> Hemophilia_____ |
| <input type="checkbox"/> Heart Disease_____ | <input type="checkbox"/> Cancer_____ | <input type="checkbox"/> Mental Illness_____ |
| <input type="checkbox"/> Alcoholism/Drug Abuse_____ | | <input type="checkbox"/> Other_____ |

Name of person completing this form: _____

Relationship to student: _____

**CHRISTIANA CARE HEALTH SERVICES
HIGH SCHOOL WELLNESS CENTER
PARENTAL CONSENT FOR TREATMENT**

_____, give my consent for _____
(Parent / Guardian name) (Student's name)
to receive services at the School-Based Health Center, administered by the Christiana Care Health Services.

IF YOU WISH TO DECLINE A SERVICE LISTED FOR YOUR CHILD, CROSS OUT AND INITIAL IN FRONT OF THAT SPECIFIC SERVICE.

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EDUCATION

- Individual and group education
- Anger management
- Smoking prevention and cessation
- Preventative education on teen risks and common teen concerns

BY SIGNING THIS CONSENT, I UNDERSTAND AND AGREE WITH THE FOLLOWING:

- The School-Based Health Center **DOES NOT** provide the following services: hospitalization, distribution or prescription of birth control or condoms, treatment of complex medical or psychiatric conditions, x-rays and complex lab tests.
- In general, visit and medical record information is kept confidential and will only be shared with others (including parents, school personnel and community resources) with the student's permission. Pertinent health information (ex. serious allergic reactions, immunizations, etc.) may be shared between the school nurse, the Wellness Center staff and your student's primary care provider in order to coordinate health services. If there is a concern for your student's safety or medical condition the parent/legal guardian and appropriate resources will be contacted. Information required to be reported by law will be reported as required.
- All information requested on the Registration/Health History Form is accurate and complete.
- Services are provided at no cost.
- Consent may be withdrawn at any time by the parent or guardian.
- I have read and completed this consent form.
- I have had the opportunity to receive and review The Wellness Center Notice of Privacy Practices brochure.

(Signature of Parent/Legal Guardian) (Relationship)

(Printed Name of Parent/Legal Guardian)

Date

(Signature of Student)

(Printed Name of Student)

Date