

# Warrior Wellness Center Enrollment Form

WARRIOR WELLNESS CENTER  
AT CHS



M+  
MarillacHealth

Healthy Kids Learn Better

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's 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

### PLEASE COMPLETE BOTH SIDES

#### 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	X	TRANSGENDER WOMAN/ TRANSGENDER FEMALE
NATIVE HAWAIIAN	OTHER PACIFIC ISLANDER	RUSSIAN	SOMETHING ELSE		TRANSGENDER MAN/ TRANSGENDER MALE
NOT PROVIDED		SPANISH	DO NOT KNOW		OTHER
X		OTHER	CHOOSE NOT TO DISCLOSE		CHOOSE NOT TO DISCLOSE
X					

970-200-1603

## 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: \_\_\_\_\_

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