# Tiger Wellness Center Enrollment Form

**Healthy Kids Learn Better**

The Tiger Wellness Center (TWC) is an integrated health center inside of Grand Junction 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 integrated health centers miss less school. Parents or guardians need to sign their student up for integrated health center services. Student access may be removed at any time with written notice. Services are open to all students and staff of Grand Junction 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 TWC 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 where you receive mail. 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 Integrated 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. **YES_____ NO _____**

Signature Required _____ Date_____

## Contraceptive Services Consent

Contraceptive Services are provided onsite only for those with parent consent or if the individual is 18 years and older. I consent for my student to receive contraceptive services at the integrated health center. Parent or guardian must approve prior to being given and this can be done via verbal consent over the phone. **YES____ NO _____**

Signature Required _____ Date_____

## Healthy Smiles Program

This integrated 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 receive 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

*** We do not yet offer dental cleaning at TWC, but it is coming soon. Your 'Yes' in response to the question above indicates that when cleanings become available, your child may participate.**

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 Tiger 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 ($5)

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 theTiger Wellness Center. I understand that my child's attendance, vaccine records, basic information and school schedule may be shared between school and Integrated care center staff as allowed to provide quality care for my child. I hereby acknowledge that I have been offered a copy of the integrated health center's Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available on the MarillacHealth 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 integrated 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 MarillacHealth / Tiger 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 TWC enrollment requirements _____YES _____Please Initial

Signature: _____ Date: _____