



200 Health Center Drive - P.O. Box 590 - Union, WV 24983 - Phone: 304-772-3064 - Fax: 304-772-3296

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

Monroe Health Center will once again open Wellness Centers in the upcoming 2009-2010 school year. They will be located at Mountain View Elementary/Middle School, Peterstown Elementary/Middle School, James Monroe High School, and Craig County High School.

The Wellness Center will give your child an opportunity to be seen by licensed health care providers without having to miss much school time. You do not have to be present for your child to be seen, but a consent form must be signed by you in order for any services to be rendered.

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.

The hours for these Wellness Centers will be as follows:

Mountain View Wellness Center	772-4580	Monday-Friday	8:00 am-11:30 am
Peterstown Wellness Center	753-6960	Monday-Friday	8:00 am-12:00 pm
James Monroe Wellness Center	753-5940	Monday-Friday	12:30 pm - 4:00 pm
Craig County Wellness Center	864-6322	Monday-Friday	8:00 am-11:00 am

Attached is a consent form, please complete and return as soon as possible. If you have any questions please call. Monroe Health Center wishes your child a fun but safe year!

Sincerely,

Shannon Parker, MBA  
CEO

**Wellness Center Parent Consent Form  
2009-2010 School Year**

Child's Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone # \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

E-mail: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relation to Child \_\_\_\_\_

Cell # \_\_\_\_\_ Work # \_\_\_\_\_ May we contact you at work? \_\_\_\_\_

Is your child allergic to any medications? Yes \_\_\_ No \_\_\_ If yes, what? \_\_\_\_\_

Does your child have any other allergies such as food, pollens, insect bites, etc.? \_\_\_\_\_

List any medications your child is currently taking: \_\_\_\_\_

Do you have any other health concerns for your child? \_\_\_\_\_

If we need to call in a prescription for your child, what pharmacy would you like for us to use? \_\_\_\_\_

Please list two alternate contacts (adult relative or friend) who will know how to contact you in case of an emergency.

1. Name of Contact: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Contact's Phone # \_\_\_\_\_

2. Name of Contact: \_\_\_\_\_ Relation to child: \_\_\_\_\_

Contact's Phone # \_\_\_\_\_

Please check if you would like your child to receive a physical/sports physical.

By signing this form, I agree to allow my child to be seen by a licensed health professional at the school wellness center and that there may be times when it will be necessary for school staff and wellness center staff to share student medical information.

**SIGNATURE OF PARENT OR LEGAL GUARDIAN**

\_\_\_\_\_ **DATE:** \_\_\_\_\_

