

MESH (Mobile Expanded School Health)  
Wilkes County Health Department  
306 College Street, Wilkesboro, NC 28697  
(336) 957-7043

**CONSENT FORM FOR MESH**

**WILKES COUNTY HEALTH DEPARTMENT- WILKES COUNTY PUBLIC SCHOOLS**

A copy of the "Notice of Privacy Practices" for Wilkes County Health Department/MESH Services is located on the Health Department website: [www.wilkeshealth.com](http://www.wilkeshealth.com) and on the MESH Unit.

I am granting permission for my child/self to enroll in the MESH Program and consent to his/her receiving health related services which can include examinations, immunizations, health screening, limited diagnostic test (eg. throat cultures, blood work), education, counseling, referrals, and/or administration or prescription of necessary medications.

I understand that health records are the property of the Wilkes County Health Department and that information contained in them will be confidential in accordance with state law and accepted medical practice. I hereby grant permission for the Health Department to submit claims for services rendered to the insurance company/companies indicated below. I understand that any services billed by outside agencies, (e.g. LabCorp) will be my responsibility.

I give my consent for Wilkes County Health Department to use and disclose health/medical information for the purposes of treatment, payment, and health care operations.

I understand that my health information may be discussed with the Wilkes County Public School nurse. A copy of the MESH visit may be sent to the medical provider on file with the MESH unit.

I understand that under North Carolina State Law a minor (under the age of 18) may receive treatment and/or advice about sexually transmitted disease, pregnancy, drug abuse, and mental health. NO BIRTH CONTROL WILL BE GIVEN NOR REFERRALS MADE FOR ABORTIONS (Services Allowed under G.S. 90.21 (a) only)

SIGNATURE OF PARENT/GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_  
SIGNATURE OF STUDENT \_\_\_\_\_ DATE \_\_\_\_\_

**STUDENT INFORMATION**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
Date of Birth \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ SS# \_\_\_\_\_  
Who is the student's doctor? \_\_\_\_\_

**PARENT/GUARDIAN INFORMATION**

Mother: Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_  
Father: Last Name \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
Employer Name \_\_\_\_\_ Employer Phone \_\_\_\_\_

**INSURANCE INFORMATION**

Do you have insurance? YES: \_\_\_\_\_ NO: \_\_\_\_\_  
Insurance Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_  
Policy Holders Name \_\_\_\_\_ D.O.B \_\_\_\_\_  
SS# \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_ Group Number \_\_\_\_\_

**MEDICAID INFORMATION**

Medicaid: Yes \_\_\_ No \_\_\_ Medicaid Name: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_  
ID# \_\_\_\_\_ Certification Period \_\_\_\_\_