La Clínica **SCHOOL-BASED HEALTH CENTERS**

PARENT/ LEGAL GUARDIAN CONSENT FORM

❑ **TECHNICLINIC**
Oakland Technical High School Health Center
4351 Broadway
Oakland, CA 94611
(510) 879-1907

❑ **TIGER CLINIC**
Fremont High School Health Center
4610 Foothill Blvd.
Oakland, CA 94601
(510) 434-2001

❑ **HEALTHY START CLINIC**
San Lorenzo High School Health Center,
50 E. Lewelling
San Lorenzo, CA 94580
(510) 317-3164

❑ **ROOSEVELT HEALTH CENTER**
Roosevelt Middle School
1926 19th. Avenue
Oakland, CA 94606
(510) 535-2893

❑ **HAWTHORNE CLINIC**
Urban Promise Academy & World & Achieve Academies
1700 28th Avenue
Oakland, CA 94601
(510) 535-6440

❑ **HAVENSCOURT HEALTH CENTER**
Roots, Coliseum College Prep Academy
1390 66th Ave,
Building B
Oakland, CA 94621
(510) 639-1981

Student's Name: _____ Name of School: _____Grade: _____ Birthdate: _____

Name(s) of Parent/Legal Guardian: _____

Student's Address: _____

Home Phone: _____ Work Phone: _____ Emergency Phone: _____

Type of Insurance: ❑ *Medi-Cal* ❑ *Alameda Alliance* ❑ *Blue Cross* ❑ *Kaiser* ❑ *Other Private:* _____ ❑ *None*

I/We have read and understand the services offered at the School Health Center as described in the attached information. I/We understand that the services authorized by my/our signature on this form are limited to routine health services and treatment which may include, but are not limited to:

1) Diagnosis/treatment of minor and acute illnesses; first aid for minor injuries

2) Assistance with chronic (on-going) illnesses

3) Physical examinations for sports or pre-employment clearance

4) Immunizations

5) Laboratory services

6) Vision screenings

7) Over-the-counter and basic prescription medications

8) Mental Health Counseling

9) Education concerning: nutrition; drug and alcohol abuse prevention; violence prevention; mental health; sexually transmitted disease and pregnancy prevention

10) Dental screenings and treatment – **AT PARTICIPATING SITES ONLY**
During school-wide dental screenings, a licensed dental professional will examine your child's teeth and determine if they are in need of dental care. This screening does not include x-rays and does not replace an in-office dental examination. If a problem is detected, you will need to make a follow-up appointment with your dental provider; or the School Health Center staff may be able to assist you with a dental appointment on-site.

____ Yes, I would like help with a dental appointment.

____ I do not need assistance with a dental appointment, my child already has a dentist.

11) Referrals for health services which cannot be provided at this clinic

Please note: California State Law (California Family Code 6924-6929) permits for the provision of certain services to adolescents, 12 years and older, with or without parental consent. These services include: diagnosis and treatment of sexually transmitted infections, HIV counseling and testing, pregnancy counseling and testing, contraceptives, referrals for prenatal care, and mental health counseling in situations specified by the law.

Please list any services offered at the School Health Center you **do not want** your child/ward to receive:

_____

_____

I/We understand that this consent covers only those services provided at the School Health Center and no other private or public health facility. I/we hereby authorize a physician and other professional Health Center staff to provide necessary and/or advisable treatment for my daughter/son/ward. This student has my/our permission to receive all services offered at the School Health Center, except those that I/we have specifically excluded above. Students may be asked to register for Medi-Cal at the Health Center. In some instances family income may be a factor in determining eligibility; eligibility may depend on the type of medical or mental health service utilized by the student.

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Medical records will be kept confidential. However, I/we acknowledge that the services for my child's condition may require the collaboration of other agencies and services providers. I/We understand that this collaboration may require the disclosure of information about my child to one or more service providers to facilitate coordination of services for my child. I/We acknowledge that the School Health Center may be required to release information regarding treatment to third-party payers, such as Medi-Cal, for the purpose of billing. Additionally, records may be released for any reason in accordance with acceptable medical practice and pursuant to law, including, but not limited to the following reasons: (1) If a student expresses a will to hurt herself/himself; (2) If a student expresses she/he may hurt someone else; and, (3) If a student claims someone is physically, sexually, or emotionally abusing her/him.

In order to improve our services, we are participating in a County-wide evaluation of School-Based Health Centers. The evaluation is being conducted by the University of CA, San Francisco (UCSF). As part of this evaluation, we collect information on the students who use our services. This information is shared with UCSF in aggregate (group) form without names or personally identifying information. We will not share your child/ward's personal information with the evaluators without your permission. By signing this form, you are agreeing to your child/ward's participation in this evaluation.

I, _____ (name of parent/legal guardian) authorize the School District to grant _____, the on-site provider at _____ (name of school) authorization to review my daughter/son/ward's student records. _____ (name of on-site provider) agrees not to disclose the student's records to any other person or entity without first obtaining my written permission.

I/We have completed the attached medical history form to the best of my/our knowledge. This consent form will remain in effect until this student's enrollment terminates, or until I/we revoke this contract in writing.

_____ _____

(Signature) Parent/Legal Guardian Date

PARENT/LEGAL GUARDIAN EMERGENCY OR WORK PHONE: _____

MEDICAL RELEASE FORM

I hereby authorize the School-Based Health Center staff and provider named below to exchange information concerning my child for the purpose of medical evaluation and treatment. I understand this consent will not expire until I revoke it or my child/ward is no longer enrolled in a school served by a La Clínica School-Based Health Center.

_____ _____

(Signature) Student Date

_____ _____

(Print) Name of Parent/Legal Guardian Relationship to student

_____ _____

(Signature) Parent/Legal Guardian Date

_____

Address of Parent/Legal Guardian (if different from student)

HEALTH CARE PROVIDER INFORMATION

_____

Physician or Clinic Name

_____

Physician or Clinic Address and Phone Number

❑ **No Regular Provider**

Please have student return this form with the Medical History Form to the School Health Center or mail to the School Health Center checked on front of this form.

Please call the phone number listed on front of this form if you have any questions.