LifeLong Medical Care
Health Services For All Ages

PARENT/LEGAL GUARDIAN CONSENT FORM

Alliance Middle School
Elmhurst Community Prep
1800 98th Avenue
Oakland, CA 94603

West Oakland Middle School
991 14th Street
Oakland, CA 94607

Name of Student: _____ Grade _____
please print

Address: _____ School _____

Home Phone: _____ Birth date _____

As the Parent and/or Legal Guardian, I hereby give my consent for my child to receive services offered by LifeLong Medical Care (LMC) at the School Based Health Center (SBHC) under the following terms and conditions:

1. I have been informed of the services offered at the LMC SBHC and I understand that these services are routine health care services and that treatment will be limited to:
   - Diagnosis and treatment of minor and acute illnesses and first aid for minor injuries
   - Assistance with chronic (on-going) illnesses
   - Physical examinations (general, sports, pre-employment)
   - Laboratory service, dental, vision & hearing screenings
   - Immunizations
   - Prescription and over-the-counter medications
   - Diagnosis, treatment, and prevention of sexually transmitted infections
   - Pregnancy testing, prescription for contraception, and referral for prenatal care
   - Nutrition assessment and counseling
   - Individual and/or group counseling and health education relating to drugs and alcohol, physical and sexual abuse, sexually transmitted infections, HIV, pregnancy prevention, suicide, grief and loss, sexuality, school, family and general mental health.

2. I have listed below those services that I DO NOT WANT my child to receive at the LMC SBHC.

   _____

   _____

   _____

   However, I understand that California State Law permits the provision of the following services to a minor who has attained 12 years of age with or without parental consent:
   - Diagnosis and treatment of sexually transmitted diseases
   - Pregnancy testing, contraceptives and referral for prenatal care
   - Crisis mental health counseling by LMC SBHC.
   - Alcohol and substance abuse counseling

3. I understand my consent covers only those services provided at the LMC SBHC and does not authorize services to be provided at any other private or public facility.

4. I authorize LMC staff at the SBHC to exchange information regarding treatment to the Health Partners and/or other medical providers for any reason in accordance with medical practice and what is legally allowed.

5. I understand that no student or family will be charged for services at the LMC SBHC. However, it is the LMC SBHC's policy to cover expenses by billing possible third-party sources such as Medi-Cal and Family Pact. Students may be asked to register for Medi-Cal. Family income is usually not a factor in determining eligibility; rather eligibility depends on the type of medical or mental health service utilized by the student. The LMC SBHC may be required to release information regarding treatment to third-party payers, such as Medi-Cal or Family Pact for the purpose of billing.

6. I, _____ (name of parent) authorize the Oakland Unified School District to grant LMC, the on-site health provider, authorization to review my child's pupil records. LMC agrees not to disclose the pupil records to any other person or entity without first obtaining my written permission.

   _____ (signature) _____ (date)

All information between your child/guardian and LMC is held strictly confidential unless (1) you authorize the release of information, (2) the disclosure is allowed by a court order, (3) the student presents a physical danger to her/him self or to others, or (4) child or elder abuse/neglect is suspected. In cases of potential abuse or neglect, LMC staff is required by law to inform the proper authorities so that the protective measures can be taken. If your student/family is receiving services through more than one LMC partner, relevant information may be shared between program staff in order to coordinate services. Staff should discuss with you such conversations and their relevance.

In order to improve services, the LMC SBHC participates in a County-wide evaluation of School Based Health Centers. The evaluation is being conducted by the University of California at 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 identifying information. We will never share your child/guardian's personal information with the evaluators or anyone else outside of the LMC SBHC without your permission.

All participants are accepted into the program on a nondiscriminatory basis, and are accorded equal treatment and services without regard to race, color, sex, sexual orientation, religion, nation of origin or ancestry. Your rights include, but are not limited to the following:

- Services which are courteous, dignified and reliable.
- A safe and comfortable environment.
- To be informed by LifeLong Medical Care of the provisions of laws regarding complaints and procedures for registering complaints including, but not limited to, the address and telephone of the appropriate person.
- To discontinue services.

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I have read and understand the rights and conditions described above.

This Consent Form remains in effect until enrollment at school terminates, or until revoked in writing.

Student's Signature: _____ Date:_____

_____ Relation to Student: _____
Print Name of Parent/Legal Guardian

_____ Date:_____
Signature of Parent/Legal Guardian

_____ _____
Address of Parent/Legal Guardian Parent/Legal Guardian Emergency or Work Phone