PARENT CONSENT FORM
SCHOOL-BASED HEALTH CENTER
ELSIE ALLEN HIGH SCHOOL

Informed Consent for Treatment and Preventative Health Care

Name of Student____ Grade_________
Address____ Home Phone_______________
City____ Zip Code__________________
Student's Date of Birth___________________________________ SSN__________________
Parent/Guardian Name____
Relationship____
Address(if different)____
Parent/Guardian Employer____
Other contact phone #____

Current Services:

- Treatment of minor illnesses (sore throat, earaches, headaches, etc.) including prescription and/or dispensing of medication.
- Treatment of minor injuries
- Employment and sports physicals
- Immunizations such as Polio, Td, Tdap, Hepatitis B, Hepatitis A, Meningoccal, HPV, Varicella, MMR and flu vaccine
- Testing for tuberculosis
- Laboratory tests (anemia, urine, etc.)
- Diagnosis/treatment of sexually transmitted diseases
- Preventative health education services, including substance abuse
- Referrals for illnesses/issues not suitable for management in the health center
- Mental health services, such as crisis counseling and emotional concerns
    - \+ I authorize my minor child to be seen in individual counseling by a licensed therapist or a non-licensed, supervised therapist. (Parent's initials)__________Yes __________ NO

I give consent for the School Health Office to release health records, including immunizations and mandated screening results to the health center staff. I give my consent for the Health Center staff to communicate with the School Health Office, if this conversation would contribute to a successful treatment plan for the student.

I have read and completed this consent form for my child. This consent is valid until my child's eighteenth birthday. I further understand that I may withdraw or modify at any time this consent with written, verified notification.

I give my consent for the staff of Elsie Allen Health Center to provide those services listed.

Print Name of Parent/legal guardian____
Signature of Parent/legal guardian___________________________________ Date___________
Student signature____Date_______________
Does your child have allergies to medications? Yes_______ No___________
Medication allergies ____

INSURANCE INFORMATION

Whenever possible, the Health Center will bill your insurance plan to receive payment for medical services. If you have insurances, please provide the insurance information requested, and a photocopy of the front and back of the insurance card.

Do you have health insurance or MediCal? Yes_______________ No________________

Medi-Cal Number: ____

Name of other insurance ____

Insurance Policy # ____

Name of Policy Holder ____

Relationship to student ____

Name of Employer ____

Regular Physician _________________________________ Phone _________________

All patient information is confidential. However, we acknowledge that the Elsie Allen Health Center may be required to release information regarding treatment to third party payers, such as MediCal or insurance for the purpose of billing. We also authorize the exchange of information regarding treatment to social services or others for any reason in accordance with acceptable medical practice and pursuant to the law.