

San Antonio Clinic

Parental Consent Form

**Name of Student:** \_\_\_\_\_\_\_\_\_\_­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Grade:** \_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City: \_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_

**Home Phone Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student’s SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Student’s School ID#: \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Parent/Guardian Emergency/ Work Phone No:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Potential Services To Be Provided:

* Diagnosis and treatment of minor and acute illness (sore throats, earaches, rashes, headaches, etc.), including dispensing of prescription medications
* First aid and treatment for minor injuries
* Physical exams, including for sports and employment
* Treatment for chronic conditions such as diabetes, asthma, and epilepsy
* Immunizations
* Vision and hearing screening
* Limited laboratory tests
* Referrals to higher level care as appropriate
* Diagnosis/treatment of sexually transmitted diseases
* Mental health services, such as crisis counseling and individual counseling by a licensed therapist

**Except I DO NOT** want my child to receive the following services from the above list\*:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If you do not want your child to receive one or more of the above services, please list here.*

\*Under California law, youth do not need parental consent to receive certain health care services. Some examples of services that youth may obtain on their own, if they meet the legal requirements, include: mental health counseling; alcohol and drug abuse counseling; diagnosis and treatment of sexually transmitted diseases; and pregnancy related care. If you would like more information about these laws and the services we provide, please talk to us.

I have read and understand the services offered at the San Antonio clinic.

**I hereby authorize the health center to provide my son or daughter with simple, common, and routine health care services such as those listed above, to the extent my consent is required by law.** I understand that under federal and state laws there are certain services that my child may receive that do not need my consent. I understand that this consent only applies to services provided at the health center and does not allow any other private or public facility to provide services to my son or daughter.

**I hereby authorize the health center to give my insurance carrier(s) medical or dental record information needed to complete my son or daughter’s insurance claims.** I understand that my son or daughter’s medical and/or dental records, including immunization records, will be kept confidential but that this information may be shared with other health care providers for purposes of my son or daughter’s care and treatment.

I understand that this consent may be revoked, restricted or revised at any time in writing by me- however this will not affect services and/or treatment previously provided by health center and other prior reliance by health center on this consent.

I understand that Petaluma Health Center needs to cover its expenses and may bill third parties for these services, including any applicable health insurer, or ask students to enroll in Medi-Cal or another public insurance program, or may bill me for services based on sliding fees that are determined based on my income and family size.

**Signature of Parent/Guardian#**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*#If Caregiver does not have legal custody, complete attached California Caregiver’s Authorization Affidavit*

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Physician (If you already have one):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinic Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_