La Clínica
a california health+ center
PO Box 22210 • Oakland, CA 94623 • www.laclinica.org

PARENT/ LEGAL GUARDIAN CONSENT FORM

SCHOOL-BASED HEALTH CENTERS

❑ **TECHNICLINIC**
Oakland Technical
High School Health Center
(510) 450-5421

❑ **TIGER CLINIC**
Fremont High School
Health Center
(510) 879-2001

❑ **ROOSEVELT HEALTH CENTER**
Roosevelt Middle School
(510) 535-2893

❑ **SAN LORENZO HIGH HEALTH CENTER**
San Lorenzo High School
(510) 317-3167

❑ **HAWTHORNE CLINIC**
Urban Promise Academy and
World & Achieve Academies
(510) 535-6440

❑ **HAVENSCOURT HEALTH CENTER**
Roots, Coliseum College Prep Academy
(510) 639-1981

❑ **YOUTH HEART HEALTH CENTER**
La Escuelita Education Complex
(510) 879-1568

❑ **FUENTE WELLNESS CENTER**
Reach Ashland Youth Center
(510) 481-4556 (Medical)
(510) 481-4554 (Dental)

Youth's Name: ________________________ School: ____________________ Birthdate: ______________

Name(s) of Parent/Legal Guardian: ____

Address: ____

Home Phone: ________________ Work Phone: __________________ Cell Phone: __________________

Gender: ❑ Male ❑ Female ❑ Other Social Security # (if applicable): ____________________

Ethnicity: ____________________ Language: ________________________

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

Healthcare Provider: ____________________ Phone No. ____________________ ❑ No current Medical Provider

I/We have read and understand the services offered at the School Health Center as described below. 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 well-checks, sports, or pre-employment clearance

4) Immunizations

5) Laboratory services

6) Vision services that include eye exam and prescription eye glasses ” AT PARTICIPATING SITES ONLY

7) Over-the-counter and basic prescription medications

8) Mental/Behavioral 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.

- I would like my child to participate in the school-wide dental screenings: ❑ Yes ❑ No
- I would like my child to receive dental services at the School-Based Health Center: ❑ Yes ❑ No

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

12) Other services, including ,fitness training, group exercise classes and referrals to social services including legal assistance

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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.

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.

PARTICIPATING IN A COUNTY-WIDE EVALUATION OF SCHOOL-BASED HEALTH CENTERS

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 clients who use our services and share this information confidentially with UCSF. UCSF will never share your name or your child/ward's name or other personally identifying information in any evaluation reports.

By signing below, you are consenting to the following:

I, parent/legal guardian below, authorize the School District to grant La Clínica de La Raza, the on-site provider at my child's school authorization to review my daughter/son/ward's student records. La Clínica de La Raza agrees not to disclose the student's records to any other person or entity without first obtaining my written permission.

I understand that La Clínica de La Raza may share my child's information with my child's provider for the purpose of medical evaluation and treatment. 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

Printed Name

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