Salud Para La Gente
School-Based Health Center
General Consent for Treatment, Payment or Health Care Operations

Name of Student: ______________________________ Grade: ______________

Address: ______________________________ City: ______________

Home Phone No: ______________________________ Birth Date: ______________

School: ______________________________ Student's SS #: ______________

Parent/Legal Guardian Emergency/Work Phone No: ______________________________

I have read and understand the services offered at **Cesar Chavez Middle School** . I hereby authorize the health center to provide my son or daughter with simple, common and routine health care services such as those listed below 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.

- Diagnosis and treatment of minor and acute illness
- Diagnosis and treatment of mental health issues
- First aid for minor injuries
- Physical examinations
- Assistance with chronic ongoing illnesses such as asthma diabetes and epilepsy
- Treatment of acne and other skin problems
- Immunizations
- Vision, Dental and hearing screening
- Diet and weight control programs
- Emergency treatment
- Dental Treatment

1. I understand that this consent only applies to service provided at the health center and does not allow any other private or public facility to provide services to my son or daughter.
2. I hereby authorize that health center to give my insurance carrier(s) medical or dental record information needed to complete my son or daughter's insurance claim.
3. I understand that my son or daughter's medical and/or dental records, including immunizations 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.
4. I understand that this consent may be revoked, restricted or revised at any time in writing by me however, will not affect services and/or treatment previously provided by health center and other prior reliance by health center on this consent.

Signature of Parent/Guardian: ______________________________ Date: ______________

Print Name: ______________________________

Insurance and Financial Information

I request and authorize direct payment to the health center of any insurance benefits (HMO, private insurance, Medi-Cal, etc.) otherwise payable to or on behalf of my son or daughter for services rendered by the health center at a rate not to exceed the actual charges for those services.

For health center services – I understand that neither my son nor daughter will be charged directly for services provided by the health center. I understand that the health center will seek payment from all third party payment sources. If my son or daughter is covered by and type of health insurance, I will provide insurance information to the clinic.

Signature of Parent/Guardian: ____________________________________ Date: __________________

Print Name: ____

The health center is permitted to recover payment for such services provided on school premises. The health center is permitted to recover payment for such services from insurance companies or other third party payors (HMO's private insurance, Medi-Cal, etc.) We ask that you supply the insurance information requested below.

Medi-Cal/Medicaid # (if applicable): ____

Other Health Insurance Name: ____

Other Health Insurance Phone No: ____

Name of Insured:____

Social Security No. of Insured: ____

Insurance Effective Date: ____

For Office Use Only

Date Received: ____

Signature Verified by: ____