SAMPLE FORM A
Consent to Health Care Treatment
at [*insert name of school health clinic or provider*]

[*Insert name of health services clinic or provider*] provides health care services to students at [*insert name of school*]. Please read this form carefully and provide all the requested information to allow your child to receive health services at school.

Student/Patient Information

Name:_____ Date of birth:_____ Grade:_____
Address:_____
Cell Phone:_____Home:_____Email:_____

Parent/ Legal Guardian/ Caregiver* Information

Name:_____
Address:_____
Home Phone:_____Cell:_____Work:_____
Email:_____

1. I give permission for [*insert name of health care services provider or clinic*] to provide any of the health and mental health care services listed below, except as noted, to my child. This includes consent for any of the following, when advised or recommended by [insert *name of health care services provider or clinic*] staff:

   - Diagnosis/treatment of minor and acute illnesses, including first aid for minor injuries
   - Assistance with chronic (on-going) illnesses
   - Routine physical examinations, including exams for sports or pre-employment clearance
   - Immunizations
   - Laboratory services
   - Vision and hearing screenings
   - Over-the-counter and basic prescription medications
   - Health and wellness education
   - Mental health services, including screening, assessment, and counseling
   - Referrals for health services which cannot be provided at this clinic

   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.

2. I understand my consent covers only those services provided at [*insert name of school*]. I understand that I can change my mind later on and decide I do not want my child to get services at [*insert name of health services provider or clinic*]. If I change my mind, I will let [*insert name of health services provider or clinic*] know in writing by sending a letter to the following address:[*insert name and address of health care services provider or clinic*]. I understand that this consent form remains valid until its expiration date or until the clinic receives a written revocation from me.

3. I understand that I will not be billed directly for health services provided by [*insert name of health care services provider or clinic*] on [*insert name of school*] premises. However, I understand that [*health care services provider or clinic*] 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. I will provide my insurance information below.

Signature of Parent/Guardian/Caregiver*:_____ Date:_____

Print Name of Parent/Guardian/Caregiver*:_____

* *If Caregiver does not have legal custody, complete attached Caregiver Authorization Affidavit*

Insurance information:

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

Other Health Insurance Name & Address/phone:

_____

Insurance Policy #:_____ Insurance Effective Date: _____

Name of Insured:_____

Additional information about this clinic and services:

This school health center is operated by [*insert name of health services provider or clinic*] in cooperation with [*name of school district*]. (*Insert either sentence A or B if applicable*) (A) It is not part of, or directly operated by, [*name of school district*]. (B) It is operated by [*name of school district*]. Questions about health services should be addressed to [*insert contact information for health services provider or clinic*].

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. [*Insert contact information for health care services provider or clinic*]

CALIFORNIA CAREGIVER'S AUTHORIZATION AFFIDAVIT

Use of this affidavit is authorized by Part 1.5 (commencing with section 6550) of Division 11 of the California Family Code.

Instructions: *Completion of items 1-4 and the signing of the affidavit is sufficient to authorize enrollment of a minor in school and authorize school-related care. Completion of items 5-8 is additionally required to authorize any other medical care. Print clearly.*

The minor named below lives in my home and I am 18 years of age or older.

1. Name of minor: _____
2. Minor's birth date: _____
3. My name (adult giving authorization): _____
4. My home address: _____

   _____
5. [ ] I am a grandparent, aunt, uncle, or other qualified relative of the minor (see back of this form for a definition of "qualified relative").
6. Check one or both (for example, if one parent was advised and the other cannot be located):

   [ ] I have advised the parent(s) or other person(s) having legal custody of the minor of my intent to authorize medical care, and have received no objection.

   [ ] I am unable to contact the parent(s) or other person(s) having legal custody of the minor at this time, to notify them of my intended authorization.
7. My date of birth: _____
8. My California driver's license or identification card number: _____

Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Dated: _____ Signed: _____

(See back of this form for Notices and Additional Information)

Notices:

1. This declaration does not affect the rights of the minor's parents or legal guardian regarding the care, custody, and control of the minor, and does not mean that the Caregiver has legal custody of the minor.

2. A person who relies on this affidavit has no obligation to make any further inquiry or investigation.

3. This affidavit is not valid for more than one year after the date on which it is executed.

Additional Information:

To Caregivers:

1. "Qualified relative," for purposes of item 5, means a spouse, parent, stepparent, brother, sister, stepbrother, stepsister, half-brother, half-sister, uncle, aunt, niece nephew, first cousin, or any person denoted by the prefix "grand" or "great," or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

2. The law may require you, if you are not a relative or a currently licensed foster parent, to obtain a foster home license in order to care for a minor. If you have any questions please contact your local Department of Social Services.

3. If the minor stops living with you, you are required to notify any school, health care provider, or health care service plan to which you have given this affidavit.

4. If you do not have the information required in item 8 (California driver's license or I.D.), provide another form of identification such as your social security number or Medi-Cal number.

To School Officials:

1. Section 48204 of the Education Code provides that this affidavit constitutes a sufficient basis for a determination of residency of the minor, without the requirement of a guardianship or other custody order, unless the school district determines from actual facts that the minor is not living with the Caregiver.

2. The school district may require additional reasonable evidence that the Caregiver lives at the address provided in item 4.

To Health Care Providers and Health Service Plans:

1. A person who acts in good faith reliance upon a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is not subject to criminal liability or to civil liability to any person, and is not subject to professional disciplinary action, for that reliance if the applicable portions of the form are completed.

2. This affidavit does not confer dependency for health care coverage purposes.

California Family Code §§ 6550, 6552

SAMPLE FORM B
Student Consent to Health Care Treatment
at [*insert name of school health center*]

[*Insert name of health services provider*] provides health care services to students at [*insert name of school*]. Under California law, youth do not need parental consent to receive certain health care services, often called "minor consent" services. Some examples of "minor consent" 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 care related to pregnancy and pregnancy prevention. Youth also may be able to consent to their own health care because of their status or living situation. If you would like more information about whether you qualify for this care and the services we provide, please talk to us. If you are interested in consenting to your own care, please read this form carefully and complete.

Student/Patient Information

Name:_____ Date of birth:_____ Grade:_____

Address:_____

Cell Phone:_____Home:_____Email:_____

4. I am able to consent to my own care because:

   [ ] I am 18 years old or older
   [ ] I am married, in the armed forces, or have been emancipated by a court.
   [ ] I am 15 years old or older, living separate and apart from my parents, and managing my own financial affairs
   [ ] I am seeking "minor consent" services.

5. I understand my consent covers only those services provided at [*insert name of school*]. I understand that I can change my mind later on and decide I do not want health or mental health services at [*insert name of health services provider*]. If I change my mind, I will let [*insert name of health services provider*] know in writing at the following address:[*insert name and address of health services provider*].

6. I understand that [*insert name of health services provider*] is *required* to keep my health information protected but that in some cases, they may need or be required to share it by law. I understand that I can ask for more information about confidentiality.

7. I understand that I will not be billed directly for health services provided by [*insert name of health care services provider*] on [*insert name of school*] premises. However, I understand that [*health care services provider*] needs to cover its expenses and may bill third parties for these services, including any applicable health insurer, and that [*insert name of health care services provider*] may ask me to enroll in Medi-Cal Minor Consent, FamilyPACT, or another public insurance program.

Signature of Student:_____ Date:_____

Print Name:_____

SAMPLE FORM C
Authorization to Release Health Information

[This form is in 14-point type to comply with California Civil Code § 56.11]

Student Information

Name:_____ Date of birth:_____ Grade:_____

[*Insert name of school based health provider or clinic]* keeps medical records confidential. However, at times we may want to collaborate with other agencies, providers and school staff to provide better health care to your child – for example, to assess your child's health needs, coordinate your child's care with school staff, provide treatment or referral, or evaluate the services provided. This may require disclosing some of your child's confidential medical information to others. In most cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purposes.

1. Please initial one of the following:
   [___] I give [*Insert name of school based health provider or clinic*] permission to share or disclose medical records and medical information about my child with the persons and agencies specified under (2) below for the purposes described above. This may include contact and appointment information, immunizations, history, diagnosis, treatment and mental health records (diagnosis, progress, and medication information). This release does NOT authorize [*Insert name of school based health provider or clinic*] to disclose information regarding HIV testing, treatment or status; drug or alcohol abuse, diagnosis or treatment; inpatient mental health services; psychotherapy notes; or minor consent services[i].

   [___] I give [*Insert name of school based health provider or clinic*] permission to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under (2) below, **except** the following information:

   _____

   [*Insert name of school based provider or clinic*] and its staff must have a separate authorization from me to disclose the information I describe on this line.

2. [*Insert name of school based health provider or clinic*] may share or disclose this information with the following persons and agencies:
   [___] [*Insert Name of school*] professional health staff

[___] [*Insert Name of school*] Multidisciplinary team members
[___] Others: _____
(name or position of person or category of persons authorized to use or receive information)

3. This authorization is valid until the following date: _____
(*specify expiration date)*

Notices and Explanation of Rights:

1. I understand that [*Insert name of school based health provider or clinic*] may share or be required to share my child's health care information with certain persons or agencies for purposes of treatment, health care operations, and billing and payment, or as otherwise required by law, without needing an authorization.

2. I understand that I may revoke this authorization by writing to [*insert name and address of person to whom revocation should be directed*]. Once [*insert name of person to whom revocation should be directed*] receives my written request, this authorization will be revoked, but only to the extent that the authorization has not already been relied upon to release health information.

3. I understand that I have the right to refuse to sign this authorization. I understand that [*insert name of school based health provider or clinic*] may not deny my child treatment, payment, enrollment in a health plan, or eligibility for benefits just because I choose not to sign this authorization.

4. I understand that if [*insert name of school based health provider or clinic*] discloses information to a person or organization that is not a health care provider, hospital or health plan subject to federal confidentiality law, the information may no longer be protected by federal confidentiality law. However, I understand that California confidentiality law still may apply, and the person or agency that receives my child's medical information will not be able to disclose the information unless they have a new authorization or as required or permitted by law.

5. I understand that I have a right to receive a copy of this signed authorization.

Signature of Parent/Guardian:_____
Print Name:_____ Date: _____
Describe Relationship to Patient:_____
This form satisfies the requirements of HIPAA 45 CFR § 164.508 and California Civil Code § 56.11

[i] "Minor consent services" refers to health care services that youth can consent on their own behalf. Minors must authorize the release of this information on their own. Cal. Health & Safety Code §§ 123110(a), 123115(a)(1)

SAMPLE FORM D
Minor's Authorization to Release Medical Information
[This form is in 14-point type to comply with California Civil Code § 56.11]

Student Information
Name:_____ Date of birth:_____ Grade:_____

[*Insert name of school based health provider or clinic]* keeps medical records confidential. However, at times we may want to collaborate with other agencies, providers and school staff to provide better health care to you – for example, to assess your health needs, coordinate your care with school staff, provide treatment or referral, or evaluate the services provided. This may require disclosing some of your confidential medical information to others. In most cases, we need your permission to share this information. We will share the minimum amount of information necessary to accomplish these purposes.

1. Please initial one of the following:
   [___] I give [*Insert name of school based health provider or clinic*] permission to share or disclose medical records and medical information related to care that I consented to for myself with the persons and agencies specified under (2) below for the purposes described above.. This may include information about pregnancy; birth control; STD testing and treatment; contact and appointment information; immunizations; and mental health counseling (diagnosis, progress, information). This release does NOT authorize [*Insert name of school based health provider or clinic*] to disclose information regarding HIV testing, treatment or status; drug or alcohol abuse, diagnosis or treatment; inpatient mental health services; or psychotherapy notes.

   [___] I give [*Insert name of school based health provider or clinic*] permission to share or disclose all medical records and information as described in the paragraph above with the persons and agencies specified under (2) below, **except** the following information:

   _____
   [*Insert name of school based health provider or clinic*] and its staff must have a separate authorization from me to disclose the information I describe on this line.

2. [*Insert name of school based health provider or clinic*] may share or disclose this information with the following persons and agencies:

[___] [*Insert Name of school*] professional health staff
[___] [*Insert Name of school*] Multidisciplinary team members
[___] Parents or Guardians (In most cases, [*Insert name of school based health provider or clinic*] cannot share information with your parents about health care you consented to without your permission.)
[___] Others: _____
(Insert name or position of person or category of persons authorized to use or receive information)

3. This authorization is valid until the following date: _____
(*specify expiration date)*

Notices and Explanation of Rights:

1. I understand that [*insert name of school based health provider or clinic*] may share or be required to share my health care information with certain persons or agencies for purposes of treatment, health care operations, and billing and payment, or as otherwise required by law, without needing an authorization.

2. I understand that I may revoke this authorization by writing to [*insert name and address of person to whom revocation should be directed*]. Once [*insert name*] receives my written request, this authorization will be revoked, but only to the extent that the authorization has not already been relied upon to release health information.

3. I understand that I have the right to refuse to sign this authorization. I understand that [*insert name of school based health provider or clinic*] may not deny me treatment or eligibility for benefits just because I choose not to sign this authorization.

4. I understand that if [*insert name of school based health provider or clinic*] discloses information to a person or organization that is not a health care provider, hospital or health plan subject to federal confidentiality law, the information may no longer be protected by federal confidentiality law. However, I understand that California confidentiality law still may apply, and the person or agency that receives my medical information will not be able to disclose the information unless they have a new authorization or as required or permitted by law.

5. I understand that I have a right to receive a copy of this signed authorization.

Signature of Student Patient:_____
Print Name:_____ Date: _____

SAMPLE FORM E
Consent for Release of Educational Records
to [*Insert name of school based health provider or clinic*]

[*Insert name of school based health provider or clinic*] at times may need information contained in your child's school record in order to better assess your child's health needs, coordinate your child's care, provide treatment or referral, or evaluate the services provided. For example, the clinic staff may need to access your child's class schedule in order to arrange appointments or your contact information in order to consult with you. In addition, school staff may want to share information with the clinic staff so that they can make a referral or participate on a multidisciplinary health team. The clinic staff needs your permission to get and receive this information. Please check one of the following:

[ ] I give [*name of school*] and its staff permission to share information from my child's education record, including contact information, attendance records, class schedule, transcript, health and special education records, and testing results, with [*insert name of school based provider or clinic*] and its staff for the purposes described above. [*Insert name of school based provider or clinic*] will request the minimum information necessary to accomplish its purpose.

[ ] I give permission to share all information from my child's education record as described in the paragraph above, except the following:

_____

If [*insert name of school based provider or clinic*] and its staff need the information I describe on this line, they must contact me for a separate consent.

This consent is valid until the following date or event: _____
(Specify expiration date or event)

Student Information

Name:_____ Date of birth:_____ Grade:_____

Parent* Information

Name:_____

Address:_____

Home Phone:_____ Cell:_____ Work:_____

Signature:_____ Date:_____
(Parent must sign if student is under 18 years old. Student must sign if age 18 or older.)*

** Parent "includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian." 34 CFR § 99.3*

This form meets the requirements of 34 CFR § 99.30 of the Family Educational Rights and Privacy Act.

SAMPLE FORM F

Consent for Release of Student Health and Educational Records

[This form is in 14-point type to comply with California Civil Code § 56.11]

[*Insert name of school based health provider or clinic*]

[*Insert name of school based health provider or clinic*] at times may want to exchange information contained in your child's school based health center (SBHC) medical record or education file with others in order to better assess your child's health needs, coordinate your child's care, provide treatment or referral, arrange for payment, or evaluate the services provided. For example, the clinic staff may wish to disclose relevant information to an outside health care provider when making a referral, or school staff may want to confirm that a student they referred to the clinic has been connected with services. School staff and clinic staff are permitted to share some types of relevant information with each other for these purposes, but some disclosures of confidential medical information to school staff as well as some disclosures to agencies or individuals outside of school require your consent. Please initial all that apply:

I give [*name of school based health provider or clinic*] and [*name of school*] and their staff permission to share the information described below with these individuals or organizations:

[ ]Health care provider_____

[ ]Agency_____

[ ] Other:_____

[ ]Other:_____

Type of information to be disclosed:

[ ] I give permission to share all information from my child's SBHC medical record or education record, including contact information, attendance records, class schedule, transcript, health and special education records, and testing results.

[ ] I give permission to share all the information in my child's SBHC medical record or education record as described above, EXCEPT the following:

_____

Purpose of disclosure:_____

I understand that I have a right to receive a copy of this signed authorization.

This consent is valid until the following date: _____
(Specify expiration date)

Parent* and Student Information

Student Name:_____
Date of birth:_____ Grade:_____
Parent*
Name:_____
Address:_____
Home Phone:_____ Cell:_____
Work:_____

Signature:_____ Date:_____
(Under FERPA, parent must sign if student is under 18 years old. Student must sign if age 18 or older.)*

** Parent "includes a natural parent, a guardian, or an individual acting as a parent in the absence of a parent or a guardian." 34 CFR 99.3*