The School Based Health Center at EHS
Parent/Guardian Permission

I understand that the information in my son/daughter's medical record is confidential and will not be released to any person without my consent. I further understand that Colorado Law permits minors to obtain without parental notification reproductive health, substance abuse services, ***and mental health services which may be obtained confidentially if the student is 15 years of age or older***.
(C.R.S. 13-22-105 & 102)

I also understand that my son/daughter will be asked to complete a Health History which provides information helpful to the School Based Health Center doctors, that my son/daughter may decline to answer any questions he/she chooses, and the information provided will be strictly confidential and will not be released without my son/daughter's consent.

PLEASE PRINT (ONE FORM PER STUDENT)

Student's Full Legal Name ______________________________
Last First Middle

Student ID Number ______________________

Student's Date of Birth ______________________ Grade ________ Gender (circle) M F

Address ______________________ City ______________ State ________

ip Code ______________________ Home Phone ______________

Father/Guardian Name ______________________ Work Phone ______________

Mother/Guardian Name ______________________ Work Phone ______________

Other person to contact in emergency ______________________ Phone ______________

Student's Race/Ethnic Group (optional - please circle one)

American Indian Asian African American Latino/Hispanic Caucasian Other __________

Is the student covered by Medicaid? Yes No Medicaid Number ______________

Is the student covered by insurance other than Medicaid? Yes No

Name of Insurance ______________ ***Insurance Ph. #*** ______________ ***Policy #*** ______________

Allergies/Major Health Problems, Medications (Please list here) ______________________

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Student's Physician (Full Name) ______________________ Phone ______________

Other pertinent information ______________________________

Approved: Health Center Advisory Committee, 1/07

(over)

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I understand the following services will be available:

- Care for acute illness and injury
- Care for common adolescent physical concerns (weight, acne, menstrual problems, smoking)
- Physical exams (including testicular, rectal, pelvic and breast)
- Routine lab tests, such as cultures, urinalysis and anemia screening
- Prescriptions for medications such as antibiotics
- Assistance in care of certain chronic conditions, such as asthma and seizure disorder
- Pregnancy testing and counseling
- Mental health assessment & short term counseling (provided by the Arapahoe-Douglas Mental Health Network)
- Drug and alcohol prevention, education, assessment and brief counseling
- Diagnosis and treatment of sexually transmitted diseases
- Information about family planning and birth control including abstinence
- Follow up as requested by Primary Care Provider
- Student health education
- Referral for HIV testing and counseling

The School Based Health Center **will not provide the following** services:

- Providing or dispensing of contraceptive devices
- X-rays
- Hospitalization
- Prescription of psychoactive drugs
- Long-term treatment of mental health problems
- Treatment of complex medical or psychiatric conditions
- Pregnancy termination
- Immunizations
- Prenatal care including delivery

I hereby give consent for ______________________________ to receive health
(Student)
services from the staff at the School Based Health Center at Englewood High School.

I understand that the School Based Health Center cannot fulfill all the health needs my son/daughter may have. If he/she does not already have a primary care provider, I understand the Health Center can provide a list of available options. I give consent for the Health Center staff to ask my student about satisfaction with their visit and understand that the information will remain confidential. I understand that some data may be used in aggregate to assess whether the needs of the community are being met.

I have read and completed this consent form. I may call Englewood High School's Health Office (303-806-2219) concerning any questions I may have.

Optional Student Consent: I agree to share with my parent/guardian information I receive in the Health Center.

______________________________ ______________________________

Signature of Parent/Guardian Date | Signature of Student *(optional)* Date

Approved: Health Center Advisory Committee, 1/07