Dear Parent(s) or Guardian(s):

Thank you for signing up your child to the Fremont Wellness Center! All of our services are free and confidential. In order to schedule an appointment if you are under 18 years old, we need a signed consent form at the start of each year in order for to be seen in the school clinic. The consent form is attached to this letter. Please fill out the attached forms in this packet in black ink.

We will need the following information on the day of your appointment:

1. A completed Consent Form attached to this packet.
2. A copy of your immunization record either from your parent or from the Nurse’s office
3. Your health insurance card. If you do not have health insurance, let us know and we can help you get it.

If you do not have a copy of your immunization record or any type of health insurance, please let us know. We would be happy to provide you with a new immunization record as well as provide you with insurance enrollment opportunities.

Please be sure to fill in each child’s name and complete all information on front and back of the form.

Signing the consent form does not change your child’s doctor.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

A SIGNED CONSENT FORM WILL ALLOW YOUR CHILD TO RECEIVE:

• Treatment for illness (strep throat, ear infections, pink eye, ringworm)
• Treatment for injuries (scraps, sprains, cuts)
• Treatment for asthma attacks, etc.
• Screening for vision and hearing.
• Tylenol for pain and other medication/treatments.

YOUR CHILD(REN) COULD ALSO PARTICIPATE IN THE FOLLOWING SERVICES IN YOUR CHILD’S SCHOOL:

• Immunizations (parent or guardian must be present)
• Yearly physical exams (check-ups).
• Treatment for chronic conditions (such as asthma, diabetes, ADHD).

We accept most health insurance. We also see children without insurance. Your child(ren) cannot receive services without a signed consent form. Please fill out your consent form and return it today.

Revised July 2, 2013
Estimado(s) padre(s) o tutor(es):

¡Gracias por inscribir a su hijo/a en el Fremont Wellness Center! Todos nuestros servicios son gratis y confidenciales. Para planificar una cita para menores de 18 años, necesitamos un formulario de consentimiento en el comienzo de cada año escolar. El formulario de consentimiento se adjunta a la presente carta. Por favor llene las formas siguientes en tinta negra.

**Necesitaremos la información siguiente en el día de su cita:**

1. Un formulario de consentimiento para padres adjunta a este paquete.
2. Una copia de su registro de la inmunización, de sus padres o de la oficina de Enfermera de Escuela.
3. Su tarjeta de seguro de enfermedad. Si no tiene seguro medico, nosotros le podemos ayudar a recibirlo.

Si usted no tiene una copia de su registro de la inmunización o cualquier tipo de seguro de salud, por favor díganos. Nosotros le podemos proporcionar con un nuevo registro de inmunización y podemos proporcionar con oportunidades de inscripción a seguro de salud.

Por favor, asegúrese de escribir el nombre de cada niño y completar toda la información en frente y detrás de la página. La firma del formulario de consentimiento no cambia el médico de su hijo

~~~~~~~~~~~~

UN CONSENTIMIENTO FIRMADO PERMITIRA QUE SU HIJO(A) RECIBA:

- Tratamiento para enfermedades (infecciones del oído, garganta/anginas, conjuntivitis, tiña)
- Tratamiento para heridas o lesiones (raspaduras, torceduras, cortes)
- Tratamiento para ataques de asma, etc.
- Detección para la visión y la audición.
- Recibir Tylenol para el dolor y otros medicamentos / tratamientos.

SU HIJO(A) PODRÍA PARTICIPAR EN LOS SIGUIENTES SERVICIOS EN LA ESCUELA DE SU HIJO:

- Vacunas (padre o tutor debe estar presente)
- Exámenes físicos anuales (chequeos).
- Tratamiento para enfermedades crónicas (como el asma, la diabetes, TDAH).

Aceptamos la mayoría de seguros de salud. También vemos que los niños que no tienen seguro. Su hijo(a) no puede recibir servicios sin una forma de consentimiento firmado. Por favor llene el formulario y entregelo hoy.

Revised July 2, 2013
Parent/Legal Guardian/Conservator Consent Form

First Name: ______________________ Last Name: ______________________ Middle: _____________ Suffix: __________
Grade: ________ School: __________________________________ SLC: ______________ Date of Birth: __ / __ / __
Address: __________________________________ City: __________ Zip Code: ______________
Home Phone #: __________________________ E-Mail: ______________________
Emergency Contact Name: ________________ Emergency Phone #: ________________ Student SS#: ____________

I/We have read and understand the services offered at the Fremont High School Wellness Center (FHSWC) as described below. I/We understand further that the services authorized by my/our signature on this form are simple, common or routine health care services, and treatment will be limited to:

1. Diagnosis and treatment of minor and acute illnesses
2. Physical examinations (general, sports, pre-employment)
3. Assistance with chronic (ongoing) illnesses, such as asthma and diabetes
4. Treatment of acne and other skin problems
5. Immunizations
6. Vision and hearing screening
7. Laboratory Services
8. Nutrition and weight control programs
9. Diagnosis of mental health issues
10. First Aid for minor injuries
11. Limited prescriptive and over-the-counter items
12. Referrals for health care services, which cannot be provided at the FHSWC

I understand that this consent covers only those services provided at the FHSWC or the UMMA Community Clinic (UMMA) main site, which is a result of a referral made by the FHSWC. I/We understand that under California State law, minors are legally able to consent for certain services without parental permission. Confidentiality will be broken in cases that harm the health and/or safety of yourself or your child.

I/We understand that no student will be charged directly for services at FHSWC. All third party payment sources will be billed. Grant funds will be used to support services rendered to students without insurance or Medi-Cal. If my child is covered by any type of health insurance, I will provide insurance information indicated on the back of this form.

I/We understand that UMMA Community Clinic can electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care and hereby consent to enroll in the ePrescribe Program. I/we understand that UMMA can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payers for treatment purposes.

Medical records will be kept in a confidential manner, however, I/we acknowledge that the FHSWC may release information regarding treatment to third-party payers such as Medi-Cal or insurance companies for the purpose of billing. I/we also understand that public information such as immunization history or illness of public health hazard and/or any other medical information may be shared with the school nurse or school physician to protect the health of other students or to the public health department to protect the health of the public in accordance with the California Health and Safety Code. I/we understand that UMMA privacy policy is published in the UMMA Notice of Privacy Practices.

If you have any questions about our Notice of Privacy Practices, please contact:
Susana E. Flores
711 W. Florence Ave.
Los Angeles, CA 90044

I/we understand that only immunization records will be shared between school nurse and FHSWC in order to maintain updated student health records as required by the Los Angeles Unified School District.

I understand that this consent may be revoked, restricted, or revised at any time in writing by me.

Name of Parent/Guardian/Conservator: ______________________ Relationship to Student: ________________
Address (if different from above): ______________________ City: __________ Zip Code: ______________
Preferred Language of Parent/Guardian/Conservator: ☐ English ☐ Spanish ☐ Other: ______________________

Signature of Parent/Guardian/Conservator: ______________________ Signature of Student: ______________________ Date: ______________________

(over) →
EXPIRATION DATE
This consent form is valid for the duration of this student’s enrollment in Fremont High School or other participating schools covered by UMMA Clinic’s Fremont Wellness Center.

INSURANCE INFORMATION

Does your child have health insurance coverage? ____ YES _____ NO

If YES, please fill out the following information:

While no charge will be made directly to you for any health services provided on school premises, the Wellness Center is permitted to recover for such services from third party payers. Therefore, we ask that you supply the Medi-Cal and insurance information requested.

MEDI-CAL# (IF APPLICABLE): ___________________________ ISSUE DATE: ___________________________

OTHER HEALTH INSURANCE: ________________________________________________________________

HEALTH INSURANCE/MEMBER ID NUMBER: __________________________________________________

NAME OF INSURED: __________________________________ RELATION TO STUDENT: __________________

SOCIAL SECURITY NUMBER OF INSURED: __________________ DATE OF BIRTH OF INSURED: _____________

***AT STUDENT’S FIRST VISIT AT THE FHSWC, PLEASE HAVE HIM/HER BRING MOST UPDATED IMMUNIZATION RECORD SO THAT THE HEALTH CENTER CAN MAINTAIN ACCURATE FILES AND ADMINISTER APPROPRIATE VACCINES***

THANK YOU!

FOR OFFICE USE ONLY

Date Received: __________________________________________

Received By: ___________________________________________ Title: ________________________________

UMMA COMMUNITY CLINIC