LOS ANGELES UNIFIED SCHOOL DISTRICT
Student Medical Services
644 W. 17th St. Building B. Los Angeles, CA 90015
Tel. (213) 763-8342 Fax. (213) 763-8358

PARENT/LEGAL GUARDIAN CONSENT FORM

NAME OF STUDENT: _____ **GRADE** _____ **TRACK** _____

ADDRESS _____

_____ **HOME PHONE** _____

BIRTHDATE _____ **SOCIAL SECURITY NUMBER** _____

PARENT/LEGAL GUARDIAN EMERGENCY OR WORK PHONE NUMBER: _____

I/We have read and understand the services offered by the school physician 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. First aid for minor injuries
3. Physical examinations (general, sports, pre-employment)
4. Assistance with chronic (ongoing) illnesses, such as, asthma, diabetes and epilepsy
5. Treatment of acne and other skin problems
6. Immunizations
7. Vision and hearing screening.
8. Mental health counseling
9. Prescriptive and over-the-counter items
10. Diet and weight control programs
11. Alcohol and other drug abuse counseling and referral
12. Referrals for health care services
13. Laboratory services

I have listed below those services, which I do NOT want this student to receive by the school physician.

_____

_____

I/we hereby authorize a physician and other professional clinic staff to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive all services offered at the school, except those which I have specifically excluded above.

I/WE UNDERSTAND THAT NO STUDENT OR HIS/HER FAMILY WILL BE CHARGED DIRECTLY FOR SERVICES. All third party payment sources will be billed.

Medical Records will be kept in a confidential manner, however I/We acknowledge that Student Medical Services 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 and/or communicable disease may be shared with the school nurse to protect the health of other students.

Signature of Parent/Legal Guardian _____ **Date** _____

Relationship to student: _____

Signature of student _____ **Date** _____

Address of parent or legal guardian if different from above _____

_____ **Telephone** _____

Signature verified by (OFFICE USE ONLY) _____ **Date** _____