

**PARENT CONSENT FORM
SCHOOL-BASED HEALTH CENTER**



SECTION I

Student Name: _____ Date of Birth: _____ Student ID Number: _____

Address: _____ Zip Code: _____

I give my permission for the School-Based Health Center (SBHC) to provide medical care and mental health counseling services to the student named above.

I understand the following types of services are offered through the SBHC:

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness
- Treatment of minor injuries, e.g., acne, strep throat, asthma, etc.
- Vision, dental, and blood pressure screenings
- Age-appropriate reproductive health services, e.g., abstinence counseling, education, exams, and referrals
- Immunizations
- Finger sticks, blood draws, and laboratory testing
- Health education, counseling, and wellness promotion
- Nutrition education and weight management
- Prescription medications
- Mental health services (screening, assessment and treatment)
- Classroom presentations
- Referral for health care services which cannot be provided at the School Based Health Center

Your insurance may be billed for this service. However, no student needing care will be turned away due to lack of health insurance or ability to pay.

SECTION II (select one)

I give permission for my child to receive SBHC services and for SBHC staff to access my child's class schedule (for appointment purposes, only). *I also give permission for the SBHC staff to consult with and provide information and records to other health care and mental health providers, including school health professionals, and for purposes of program evaluation and quality assurance.*

OPT-OUT: I do not give permission for my child to receive SBHC services (note exception below*)

SECTION III

Student's Health History:

Allergies to Medicine: _____

Medication Taken Daily by Student: _____

Major Medical Problems/ Past Surgeries (e.g. asthma, diabetes, seizure disorder, depression, tonsillectomy):

SECTION IV

PRINTED NAME Parent/Guardian

Daytime Phone

Date

SIGNATURE Parent/Guardian

* Parental consent is not required for, and shall not bar children, regardless of age, from the following services: Any person regardless of age may consent to: Venereal disease examination and treatment (NMSA 24-1-9); Examination and diagnosis for pregnancy (NMSA 24-1-13); Family planning services should be readily accessible to all who want and need them (NMSA 24-8-5); Individual or group psychotherapy or any other forms of verbal therapy, including substance abuse services that does not include aversive stimuli or substantial deprivations. This does not include electro convulsive therapy or psychotropic medications (NMSA 32A-6-14). SBHC staff makes every effort to encourage discussion between the student and parent/guardian regarding these subjects. Emergency treatment may be given when a parent or guardian cannot be reached (NMSA 24-10-2).