RESET RESET

**De Anza College Student Health Services**
21250 Stevens Creek Blvd. Cupertino, CA 95014
Phone: (408) 864-8732 Fax: (408) 864-8983

## CONSENT FOR MEDICAL TREATMENT OF A MINOR STUDENT

| Print Name of Minor Patient | Birth Date | Student ID# |
|---|---|---|
| Print Name of Parent or Guardian | Relationship | Parent or Guardian Phone # |

_____ **(Initials)** I hereby give consent and authorization for any emergency or non-emergency diagnostic procedures and treatment that may be performed on an outpatient basis and which may include but are not limited to laboratory procedures, x-ray examinations or medical treatment, done at De Anza College Student Health Services by or under the instruction of the patient's health care provider. **My California Driver's License or valid form of identification is attached.**

_____ **(Initials)** In my absence, I would like the health care provider to discuss the matter with the persons designated below or the person's name under the **California Caregiver's Authorization Affidavit form**. I authorize those persons, insofar as the law of California permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

**Additional Names:**
Name: _____ Phone number: _____
Address: _____

Name: _____ Phone number: _____
Address: _____

**This authorization will remain in effect until the 18th birthday of listed minor.**

_____ _____
Signature of Parent or Guardian (circle) Date and Time

**Return this form via in person, fax, US Mail or Email (email is not secure):**
**Fax**: 408-864-8983
**Mail:** De Anza College Student Health Services, 21250 Stevens Creek Blvd. Rm 166, Cupertino CA 95014
**Email address:** dahealthclerk@fhda.edu

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## Permission / Release & Waiver of Liability

**Release/Indemnification.** The Parent/Legal Guardian hereby consent to the above listed and release absolutely, forever discharge, hold harmless and covenant not to sue the Foothill-De Anza Community College District, its directors, employees, agents, volunteers and affiliates (herein collectively referred to as "District") from any and all present or future liability, claims, demands, actions or rights of action, whether asserted by me or a third party arising out of, or in connection with minor student's participation in the above activity (the "Claims"). I agree to indemnify and hold harmless the District for any such Claims brought by me or a third party from any costs associated with defending or litigating such claims, including but not limited to attorney fees, costs and legal expenses.
I understand that the Foothill-De Anza Community College District has **no legal responsibility** for the care or well-being of the minor student wherever he or she chooses to live while in the US attending Foothill or De Anza College. I also understand that the district has no relationship with any homestay company and assumes no responsibility for the actions of any host family or homestay company. I understand that in all legal issues, I am remain responsible for the care and guardianship of this minor student.

_____ _____
Signature of Parent or Guardian (circle) Date and Time

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## TREATMENT OF MINOR STUDENTS FOR BEHAVIORAL HEALTH COUNSELING

California Family Code 6900 et seq. states that unless a specific exception applies, a minor's guardian or parent must consent to behavioral health counseling. The exceptions include when the minor would present a danger of serious mental or physical harm to themselves or another without behavioral health treatment or counseling or b) if the minor is an alleged victim of incest or child abuse.

**IN CALIFORNIA, MINORS ARE INDIVIDUALS UNDER 18 YEARS OF AGE**

If your minor dependent will be enrolled as a student at De Anza College, you are to complete and return the behavioral health counseling form below.

**Student's Name (printed)** _____

**Student I.D. #**_____ **Date of Birth:** _____

**Please sign**

I hereby authorized De Anza College Psychological Services to provide to my minor dependent any behavioral health treatment or counseling that is deemed advisable, and is to be provided by any behavioral health practitioner of De Anza College Psychological Services or any outside behavioral health practitioners or facilities needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

| _____ | _____ | _____ |
|---|---|---|
| Parent/Guardian Name (print) | Signature of Parent/Guardian | Date |
| _____ | _____ | _____ |
| Student Name (print) | Signature of Student | Date |

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**FOR STAFF USE ONLY**
**PHONE AUTHORIZATION (For Medical Treatment only)**
**EMAIL AUTHORIZATION (For Behavioral Counseling only)**
**(Minor Students living in California)**

Telephone/email consent to treat the above-named minor wasgiven by: _____

Relationship to student: ☐ Parent ☐ Legal Guardian

Date:_____ Time: _____am/pm Telephone Number Called: _____

Email Address: _____

| _____ | _____ |
|---|---|
| Student Health Services/Behavioral Health Counseling Staff Name and Signature | Date |
| _____ | _____ |
| Witness Name and Signature | Date |

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# STUDENT INFORMATION – REQUIRED TO ATTEND

**All sections must be completed, with the signed original turned into the office of De Anza Student Health Services.**

**GENERAL INFORMATION**

| | |
|---|---|
| Parent/Guardian 1 First Name: | Last Name: |
| Best Number to Reach You: | Email: |
| Parent/Guardian 2 First Name: | Last Name: |
| Best Number to Reach You: | Email: |
| Special Instructions to Reach Parent(s) (if any): | |

## EMERGENCY MEDICAL INFORMATION (*Living in CALIFORNIA)

In the event of an emergency, the parent(s) listed above will be notified first. Please list additional emergency contacts below in case the parent(s) are unable to be notified. All emergency contacts below are authorized to pick up Minor Student for non-emergency purposes:

| | |
|---|---|
| Name of Emergency Contact 1: | Phone Number: |
| Name of Emergency Contact 2: | Phone Number: |
| Name of Authorized Pick up Person: | Phone Number: |
| Name of Authorized Pick up Person: | Phone Number: |
| *Physician's Name or Medical Group: | Phone Number: |
| *Medical Record Number (or other medical identification Number): | |

* It is important that proof of personal medical insurance and emergency contact information for parents/guardians is provided and carried by the minor at all times. The college and emergency medical personnel will need this critical information.

## FOOD ALLERGIES/MEDICAL CONDITIONS

| | |
|---|---|
| ANY KNOWN FOOD ALLERGIES: | |
| OTHER MEDICAL CONDITIONS THAT CLINICAL STAFF SHOULD BE AWARE OF: | |
| DIETARY LIMITATIONS: | |