The Health Center at Port Angeles High School

CONSENT FORM

I give permission to The Health Center at Port Angeles High School (PAHS) to perform such medical and therapeutic procedures as may be professionally necessary or advisable to my (or my child's) health screening, diagnosis, and treatment. I understand that a patient record will exist for each student and that I am responsible for medical expenses that may occur. (North Olympic Healthcare Network will bill your insurance company. Anything not paid by the insurance company will be billed to you.)

In the case of medical health services, the Health Center MUST have a signed Consent Form from a parent or legal guardian before health services are provided to youth.

I understand the following types of services are offered through the Health Center at PAHS:

- Routine physical exams, including sports physicals
- Diagnosis and treatment of acute and chronic illness.
- Laboratory Tests
- Referral for health care services that cannot be provided at the High School Based Center
- Mental health services
- Health education, counseling, and/or wellness promotion
- Immunizations
- Reproductive health services, like counseling, education, exams, and referrals

According to law, MINORS may provide their OWN consent for substance abuse treatment and mental health care services at the age of 13 or older. MINORS may provide their OWN consent for reproductive health care at any age. If necessary, the Health Center will inform youth of options for outside care and will assist youth in discussing these issues with parents/guardians. (RCWs: 70.96A.230; 71.34.510; 70.24.110; 9.02.100(1)).

When a student consents for his/her own care, all information is kept confidential and cannot be released except in the following circumstances when it can be confidentially shared:

- If a student shows signs of risk of suicidal behavior.
- If a student has a life-threatening health problem and is under 18 years old.
- If the student gives us permission through a signed release of information
- If student plans to do serious bodily harm to someone else.
- If there is reason to suspect abuse or neglect. This may include any sexual contact with a minor (people under 18 years old) by a person older than 18 **or** where this is a three or more year difference in ages.

Please Note: The student's consent is LEGALLY required for release of information about the following: pregnancy, sexually transmitted disease (including HIV/AIDS testing), substance abuse treatment, and/or mental health counseling.

______________________	______________________	__________
Student's Signature	PRINT Student's Name	Date
______________________	______________________	__________
Parent or Guardian Signature	PRINT Parent/Guardian Name	Date

Relationship to Student: ____

Please turn over and complete the Registration on the other side→

The Health Center at Port Angeles High School

Health Services Registration

Student's Information

First Name____________________

Last Name____________________

Date of Birth ____________ Grade in School______

Student's Identifying Gender ____________

Phone #: Cell ____________ Home ____________

Address ____________________

City ____________ State ______ Zip ___

Parent/Guardian's Information

First Name ____________________

Last Name ____________________

Relationship to Student ____________

Phone #: Cell ____________ Home ____________

Address ____________________

City ____________ State ______ Zip ________

Check all that describe student's ethnicity:

_______ Black/African American

_______ Asian

_______ American Indian/Alaskan Native

_______ Hispanic

_______ Pacific Islander

_______White

_______Other: ____________________

Student's Emergency Contact

Name ____________________

Phone #: Cell ____________ Home ____________

Relationship to Student ____________

Student lives with: please check all that apply

____Mother ____Father ___Legal Guardian

____Stepmother ___Stepfather ___Grandparent(s)

_______ Alternates Bet. Parents _______ Foster Parent(s)

_______ Emancipated Minor ___Other:____________

Insurance information

Does student have health insurance? __Yes ___No

Insurance Plan Name:____________________

Policy Number ____________________

Group Number ____________________

Subscriber Name: ____________________

Subscriber Date of Birth: ____________

Subscriber's relationship to student: ____________

Fees and Billing

No one will be denied service due to inability to pay, but the following information is required so we can bill your insurance or determine if you qualify for a sliding fee discount. If you do not wish to provide the information we will bill you at full fee for service.

Sliding Fee Program: If the student does not have insurance and does not qualify for Apple Health we can provide sliding fees for certain services.
Please Complete:

Your Gross Monthly Household Income:$__________

Number of Family Members in Your Household: ____

Please turn over and complete the Consent Form on the other side →