TUBA CITY REGIONAL HEALTH CARE CORPORATION
2006 – HIGH SCHOOL TEEN CLINIC PERMIT – 2007

STUDENT NAME ______________________________ **Grade** ___________________

Parent/Guardian Name _______________________________ **Relationship** _______________

- **Brief Medical History**

	YES	NO
Does your son/daughter have any ongoing or serious medical condition?	( )	( )
IF YES, please explain:		
Does your daughter/son take any regular medications?	( )	( )
IF YES, please explain:		
IF YES, do you give consent for the high school faculty and staff to be notified of your child's required medication?	( )	( )
Is your son/daughter allergic to any medication or food?	( )	( )
IF YES, please explain:		
Is your daughter/son able to participate in all school activities?	( )	( )
IF NO, please explain:		
Is your daughter/son currently under the care of a Mental Health professional?	( )	( )
IF YES, please explain:		

- **Consent**

I hereby give my permission for my daughter/son to receive comprehensive health care through the high school Teen Clinic. I understand that:

a. Services available through the clinic include routine health care, care for chronic illnesses, pre-participation sports examinations, specialist referral and evaluation, physical therapy, immunizations, and emergency medical care. I have received a description of the services offered through the school Teen Clinic.

b. The Teen Clinic is managed and operated by the Tuba City Regional Health Care Corporation.

c. Care in the school Teen Clinic is confidential and protected by the federal Privacy Act. Health information may only be shared between hospital and school staff for the purpose of student health maintenance.

d. In the event that my son/daughter is referred for mental health services via the Telepsychiatry Program, I authorize electronic transmission of his/her medical information and/or videoconference session so that it can be viewed by a psychiatrist and other persons involved in his/her healthcare. I understand that medical records of telepsychiatry services will be kept at both the referring site facility and the consulting site facility. I give permission for mental health clinicians in training to observe my son/daughter's telepsychiatry session and I understand that I or my son/daughter can withdraw permission at any time.

e. In the event that my son/daughter is referred for other Telemedicine services such as Dermatology or Nutrition, I authorize electronic transmission of his/her medical information as outlined above.

f. I will be notified of any serious problem requiring ongoing testing or treatment.

g. I am encouraged to participate in my son/daughter's care. While some types of adolescent health care may not require parental notification, all teens are encouraged to involve parents in their care whenever possible.

h. This permission is only given for the 2006-2007 school year. I may choose to withdraw it at any time by writing to the school nurse or Teen Clinic.

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Parent/Guardian Signature *Date*

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Parent/Guardian's Daytime Phone Number OR Person to be Contacted in Case of Emergency