Park Nicollet
HealthPartners®

School Year _____

CENTRAL CLINIC
CONSENT FOR MEDICAL CARE

Children and youth, from birth through high school graduation, who live, work or go to school in the St. Louis Park Public School District, are eligible to receive free medical care at Central Clinic. For them to receive the medical services listed below, you must complete this consent form and return it to Central Clinic.

I give permission for my child to use the medical services at Central Clinic.

Child's Name: _____ Date of Birth: _____

I will allow my child to receive **ALL*** medical clinic services, including the following:

- **Routine care:** Treatment for minor conditions such as colds, flu, infections, headaches, earaches, sore throats, sprains, cuts, burns, skin problems, stomach pain and back pain; physical exams for sports; vision & hearing screenings; and immunizations
- **Health education:** Weight management, special diet counseling, smoking prevention, and safety promotion
- **Lab services:** Routine blood and urine tests, throat cultures, and diabetes tests
- **Counseling:** Help dealing with stress, anxiety, depression, abuse and neglect, mental health, self-esteem development, and suicide prevention

*** IMPORTANT: If there are services listed above you do not want your child to receive, please cross them out. He or she will receive only those services that remain on the list. Please be aware that Minnesota Law does allow your child to receive treatment, without your permission or consent, for sexually transmitted infections, chemical dependency, and pregnancy and conditions associated with pregnancy, including pregnancy prevention.**

Allergies

My child has the following allergies:_____

Medications

My child uses the following medications:_____

Do you have medical insurance? YES _____ NO _____

We ask for this information only to coordinate with the Minnesota Vaccine for Children program. Medical visits to Central Clinic are free and your insurance will not be charged.

Signature: _____ Date: _____
(Parent or Guardian)

Relationship to student: _____ Daytime phone: _____

This consent form will be on file at the clinic and is valid for one academic year. A written consent is required annually.

Please return signed form to _____