Livingston
COMMUNITY HEALTH

PARENTAL CONSENT FORM

Minor's Name: _____ DOB: _____
Home Address: _____ City: _____ ZIP: _____
Primary Doctor: _____ Allergies to Medications or Illnesses we should be aware of: ☐ Yes ☐ No
Please list allergies to medications or illnesses: _____
If taking medications, please list: _____

Parent/Legal Guardian Name: _____ DOB: _____
Mailing Address (if different): _____ City: _____ Zip Code: _____
Primary Insurance Holder: _____ DOB: _____ Cell: _____
Employer: _____ Name of Health Insurance Company: _____
Group or ID Number: _____ If Medi-Cal/Alliance, PIN Number on card: _____
If you or your child has no medical insurance, would you like us to help you find health coverage? ☐ Yes ☐ No

Medical Services: Comprehensive physical exams; Management of acute and chronic illness; Sport, college, and employment physicals; Immunizations and Flu shots; Vision and hearing screenings; Lab tests (anemia, urine); Referrals to higher level of care as appropriate; Dental services including exams, cleanings, x-rays and fillings.

Counseling Services: Crisis management; Depression and anxiety; Behavioral, narrative, and solution-focused therapy; Relationship; Self-esteem, body image, and eating disorder counseling.

Health Education & Confidential Services: Healthy choices counseling including lifestyle, nutrition, and exercise; Drug and alcohol abuse prevention; STD and pregnancy prevention.

Under California law, minors do not need parental consent to receive certain health care services such as crisis intervention, emergency care, mental health counseling, substance abuse counseling, diagnosis and treatment of sexually transmitted diseases, family planning services, and pregnancy related care. Some information requires the minor's signed consent prior to disclosure to anyone, including parents. If you would like more information please ask us.

Consent by Minor: A minor is able to consent for his or her care if: (1) the minor is or has been married, in the armed forces, or emancipated by the court; (2) is seeking services for which parent/guardian is not required as outlined above; or (3) is 15 years of age or older, living separate and apart from his or her parents, managing his or her own affairs and satisfactory proof is provided to establish these conditions.

I understand that my child's medical records will be kept confidential, but may be shared with health care providers and Livingston Community Health (LCH) personnel for the purpose of my child's health care, treatment, and overall well-being. I understand that LCH may bill third party payers, such as Medi-Cal/Alliance or private insurance, or may bill me on a sliding fee scale based on my income and family size. I also understand that I may avoid being billed for services by providing my child's insurance information necessary for billing and/or choosing LCH as my child's primary health provider.