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

MINOR CONSENT
ACCESSING HEALTH CARE FOR STUDENTS UNDER AGE 18

If you are under 18 years of age, state law requires us to contact your parents for most treatment at De Anza Student Health Services.

In California, according to the law, a person becomes an adult at age 18 years old. Under age 18, parents have the right to make most health care decisions. This includes the right to consent to health care. Because of this law, there are times when it will be necessary to speak with a parent or guardian as part of being seen here at Student Health Services.

There are some situations when a person under 18 can get health care without parental consent. These situations are defined by California and federal laws. The following services do not require parental consent:

- Family Planning
- Sexually transmitted diseases
- Mental Health Treatment and Counseling
- Pregnancy
- Drug and Alcohol related problems
- HIV/AIDs
- Sexual Assault Treatment
- Abortion
- COVID-19 Testing
- Situations involving public health reportable infectious disease care
- Suspected Child Abuse Victims

Some people under 18 have a special status in California which allows them to seek care on their own. These include emancipated minors and minors living with complete financial independence separate and apart from their parents.

Unless your situation is listed above, we will need to contact your parents. While one of our providers will make the official required call to your parents for a verbal consent to treat, it is helpful if you give your parents a call to let them know that we will be contacting them. If you are concerned about reaching your parents, please speak with one of our providers.

If you are interested in knowing more about this issue:
http://www.teenhealthlaw.org/fileadmin/teenhealth/teenhealthrights/ca/07_CA_MinorConsentChapter.pdf

De Anza College

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 (PARENTS/GUARDIAN)
(USE PENS ONLY)

Print Name of Minor Patient	Birth Date	CWID#
Print Name of Parent or Guardian	Relationship	Parent or Guardian Phone #

_____ **(Parent/Guardian Initial)** 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 vaccine administration, 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.**

_____ **(Parent/Guardian Initial)** In my absence, I would like the health care provider to discuss the matter with the persons designated below and/or the person's name under the California Caregiver's Authorization Affidavit form. I authorize those persons(s), 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.

Designated Person(s) (*LIVING IN CALIFORNIA/STATES)

Name: _____ Phone number: _____
Address: _____

Name: _____ Phone number: _____
Address: _____

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

_____ _____
Signature of Parent/Guardian **Date signed (MM/DD/YYYY)**

RETURN THE SIGNED FORMS AND ATTACHED A VALID ID (PARENTS/GUARDIAN)
PRIOR TO SCHEDULING YOUR APPOINTMENT

****

VERBAL/PHONE AUTHORIZATION – STAFF USE ONLY

I have obtained telephone consent for De Anza Student Health Services (SHS) to provide medical care for the minor patient after speaking with the patient's parent/guardian, as listed above.

Duration of this Consent:

- ☐ This authorization will remain in effect until the 18th birthday of listed minor.
- ☐ For this visit only
- ☐ This authorization shall remain in effect until_____, 20_____, unless sooner revoked in writing and delivered to said agent(s).

Person obtaining authorization:

Print Staff Name	Staff Signature	Date and Time

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

PERMISSION/RELEASE & WAIVER 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 **Date signed (MM/DD/YYYY)**

VACCINE CONSENT FORM FOR MINOR

I, _____ **(Parent/Guardian)** attest to the following:

All boxes must be initialed in order for the minor to be vaccinated:
_____ **(Parent/Guardian Initial)** I have read and understand the Vaccine Information Statements or EUA Fact Sheets for the requested vaccine below and understand the risks and benefits (https://www.cdc.gov/vaccines/hcp/vis/current-vis.html)

___MMR **___HPV** **___Varicella** **___ Other**
___Tdap **___Hep B** **___Influenza**

_____ **(Parent/Guardian Initial)** I GIVE CONSENT for the minor patient to receive the vaccine.

_____ **(Parent/Guardian Initial)** I understand that by providing my voluntary consent, the minor patient can receive the vaccine with or without a parent or guardian being physically present at the vaccination appointment.

_____ **(Parent/Guardian Initial)** I understand that all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the patient's CAIR2 record will be shared with the local health department and California Department of Public Health, shall be treated as confidential medical information, and shall be used only as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the request to lock my CAIR record web form: https://cairforms.cdph.ca.gov/SharingReguestForm/SharingReguestForm?SharingType=1&Language=En

By signing my name and today's date below, I am providing consent for the named minor child below to receive the vaccine, and certify that (1) I am authorized to provide this consent and (2) all of the information I have provided on this form is true and correct to the best of my knowledge:

_____ _____

Name of Minor Patient **CWID**

_____ _____

Parent/Guardian Signature **Date signed (MM/DD/YYYY)**

_____

Parent/Guardian Name (print)

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

STUDENT INFORMATION – REQUIRED FOR PARENTS/GUARDIAN TO COMPLETE

All sections must be completed, with the **signed original & copy of identification** turned into the **office of 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:	