MULTNOMAH COUNTY
student
HEALTH CENTER

Name:_____
DOB:____/____/_____ ID#_____
Sex: M F

CONSENT TO TREAT

Client Name: _____ Date of Birth: _____

I give my permission for the Multnomah County Student Health Centers (SHC) to provide medical care to the client named above.

I understand the following types of services are offered through the SHC:

- Regular check-ups
- Sports physicals
- Care for illness and injury
- Immunizations
- Mental health, including counseling
- Age-appropriate reproductive health
- Routine lab tests
- Prescription medications
- Vision, dental, and blood pressure screening
- Health education, counseling, and wellness promotion
- Referrals for services like x-rays, MRI's and specialty care

Student Health Center (SHC) clinical staff share appropriate medical information with Multnomah Education Service District School Health Services nursing personnel in order to support coordination of care for students with special medical needs.

I have read the above information and have had the opportunity to have any of my questions answered.

I understand that I may revoke my consent at any time.*

_____ _____
Parent/Guardian Signature Date

_____ _____ _____
Home Phone Cell Phone Day Phone

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* *Oregon state law requires a parent or legal guardian's consent to provide medical treatment to an individual under 15 years of age except for family planning, sexually transmitted disease services and certain mental health services, ORS 109.610, ORS 109.640, ORS 109.675.*