LAS POSITAS COLLEGE

Student Health & Wellness Center
3000 Campus Hill Drive, Livermore, CA 94551
(925) 424 - 1830

Parent/Guardian Minor Student Authorization Form

This form authorizes the Student Health & Wellness Center to provide medical services and care to the below named minor student. Please note that the Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) prohibits the Student Health & Wellness Center staff from sharing information about the below named student with anyone other than the student, regardless of age. Information and records pertaining to the student are confidential. This form only needs to be completed once while the minor student remains enrolled at Las Positas College unless revoked in writing. This form may be resubmitted if information is amended.

Note: This declaration does not affect the right of the minor's parent(s) or legal guardian(s) regarding the care, custody, and control of the minor, and does not mean that the caregiver has legal custody of the minor. A person who relies on this affidavit has no obligation to make any further inquiry or investigation. This affidavit remains valid until the student turns 18 years of age.

☐ First time submitting this form | ☐ Amendment to previous form

STUDENT INFORMATION

STUDENT'S LAST NAME FIRST NAME MIDDLE INITIAL	STUDENT I.D.# (Social Security # or College ID #, NOT High School #) W# or SSN: _____ - _____ - _____
ADDRESS	PHONE NUMBER / EMERGENCY NUMBER
CITY STATE ZIP	EMAIL ADDRESS
DATE OF BIRTH	GRADE LEVEL: ☐10th grade ☐11th grade ☐12th grade

Contact information on this form will not update the student's Las Positas College account. Please visit the Admissions & Records office to update the above information.

KNOWN HEALTH CONDITIONS

Please list any health conditions that you would like the Health Center to be aware of for this student:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PARENT/GUARDIAN INFORMATION

LAST NAME FIRST NAME MIDDLE INITIAL	☐ HOME | ☐ CELL | ☐ WORK | PHONE NUMBER
ADDRESS	☐ HOME | ☐ CELL | ☐ WORK | PHONE NUMBER
CITY STATE ZIP	EMAIL ADDRESS

NOTE: A COPY OF PARENT/GUARDIAN'S GOVERNMENT-ISSUED ID MUST BE ATTACHED TO THIS FORM.

I hereby authorize my student to receive medical care at the Student Health & Wellness Center.

Signature of Parent/Guardian: _____ Date: _____

I declare under penalty of perjury under the law of the State of California that the foregoing is true and correct to the best of my knowledge.

STAFF USE ONLY | Received by: _____ | Date: _____

TR 11/30/18