Wayzata Community Clinic Student Consent

If you have children, infancy through high school, who live or attend public or private school within Wayzata, Orono or Minnetonka School District boundaries, they are eligible to receive free medical care at the Wayzata Community Clinic, 250 Central Avenue, Suite 206, Wayzata, Minnesota (use East Entrance). For your son or daughter to receive the services listed below, you must complete this consent form and return it to the clinic. Young people without a signed consent form (in hand or on file at the clinic) cannot be treated by clinic staff for the listed services.

I give permission for ______________________________ ______________

(child's name) (date of birth)

to use Wayzata Community Clinic.

I will allow my son or daughter to receive **ALL*** clinic services, including the following.

- **Routine care.** Treatment for colds, flu, infections, headaches, earaches, sore throats, sprains, cuts, burns, skin problems, abdominal pain, back pain, physical exams for sports, shots, screenings.
- **Counseling.** Help dealing with stress, anxiety, depression, abuse and neglect, sexual health, mental health services, self-esteem development, suicide prevention.
- **Health education.** Weight management, special diet counseling, smoking prevention, safety promotion, prevention of AIDS and sexually transmitted infections.
- **Lab services.** Routine blood and urine tests, throat cultures, diabetes tests.

*** IMPORTANT: If there are services listed above you do not want your son or daughter to receive, 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 son or daughter to receive treatment, without your permission or consent, for sexually transmitted infections, chemical dependency, pregnancy and conditions associated with pregnancy, including pregnancy prevention.**

Allergies—My son or daughter has the following allergies: ______________________________

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Medications—My son or daughter uses the following medications: ______________________________

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Signature: ______________________ **Relationship to student:** ______________________

(Parent or Legal Guardian)

Date: ______________________ **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.**
- **Consent forms are available at the clinic and all Wayzata Public Schools.**

Return this form to Wayzata Community Clinic, 250 North Central Avenue, Suite 206, Wayzata, MN 55391 or to your child's school health office.