SANTA ROSA JUNIOR COLLEGE

STUDENT HEALTH SERVICES

MEDICAL CONSENT FOR TREATMENT OF A MINOR

This form is designed to permit the Santa Rosa Junior College – Student Health Services to evaluate and treat your child until she or he reaches the age of 18 or sooner if revoked in writing. It allows our office to provide the following services at each visit without requesting verbal or written consent from you:

1. **Routine student health care. (For problems such as colds, minor injuries and illnesses, cuts requiring tetanus immunization, etc.)**
2. **Emergency care, first aid, and referral to local health facilities should an emergency situation arise while your child is on the SRJC campuses.**

If you have any questions regarding this form, you are welcome to call the Student Health Services office at (707) 527 – 4445 and talk to one of our Nurse Practitioners on duty.

Student's Name_____

Social Security _____

Date of Birth _____

(I) (We), the undersigned parent(s)/guardian(s) to _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical evaluation, diagnosis or treatment that may be rendered to said minor child under the general or special supervision of physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered at Santa Rosa Junior College – Student Health Services or at a licensed hospital, clinic, or doctor's office.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to render care which the staff of the SRJC Student Health Services in the exercise of their best judgment may deem advisable.

It is understood that in case of an emergency, reasonable efforts shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

This consent is given pursuant to the provisions of Section 25.8 of the California Civil Code.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____ _____ _____

Address City State Zip

Telephone where Parent/Legal Guardian can be reached:

Name: _____ Home _____ Work _____

(Please print)

Student-Athlete Name: _____ **Student ID:** _____

SANTA ROSA JUNIOR COLLEGE

STUDENT HEALTH SERVICES
Santa Rosa - Phone (707) 527-4445 FAX (707) 524-1858
Petaluma - Phone (707) 778-3919 FAX (707) 778-3901

ATHLETIC AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, the undersigned, hereby voluntarily authorize the exchange of information between the following providers and/or the authorized representatives of the following agencies/organizations as indicated. I understand that if the organization/agency authorized to receive the information is not a health care provider; Federal Privacy Regulations may no longer protect the released information.

I give permission for an ongoing exchange, between SRJC Student Health Services (SHS), SRJC Kinesiology, Athletics & Dance Department (KAD), and the SRJC Athletic Training Staff of all records that may pertain to

Athletics clearance, illnesses and/or injuries and an ongoing informational exchange of health records with SRJC Disability Resources Department (DRD) as needed for academic accommodation.

SRJC Student Health Services Department (SHS)
1501 Mendocino Ave
Santa Rosa CA 95401

SRJC Kinesiology, Athletics & Dance Department (KAD)
Including, but not limited to:
Athletic Training Staff, Coaches, & Athletic Director
1501 Mendocino Ave
Santa Rosa CA 95401

SRJC Disability Resources Department (DRD)
1501 Mendocino Ave.
Santa Rosa CA 95401

This exchange of information is for the purpose of providing effective evaluation, treatment and appropriate services. I understand that this authorization may be revoked in writing at any time, except on the following date or under the following condition(s): _____

Sensitive Information Release
Do not release any sensitive information related to AIDS and/or HIV infection or treatment for Alcohol and/or drug abuse.

I further understand that the information provided to Student Health Services is going to be kept **CONFIDENTIAL** and is protected by Federal Privacy Regulations. I also understand that Student Health Services is not responsible for any mishandling of my information by other agencies/organizations whom I have authorized the information released to.

Signed:_____ **Date:**_____
If student-athlete is a Minor, the Parent or Legal Guardian must sign Authorization to Release Information.

Print Name:_____ **Date:**_____

AUTHORIZATION and CONDITIONS TO TREAT

I hereby authorize the health care providers at Student Health Services, and their agents or consultants, to perform diagnostic and treatment procedures that, in their judgment, may become necessary while I am at Santa Rosa Junior College. I understand that it is my responsibility to arrive at my appointments on time, and to cancel appointments, if necessary, with as much advance notice as possible. Failure to keep or cancel scheduled appointments may result in termination of services.

Signed:_____ **Date:**_____
If Minor, parent or guardian must sign the Medical Consent for Treatment of a Minor form

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ASSUMPTION OF RISK

I acknowledge that while I am participating in intercollegiate athletics at Santa Rosa Junior College (SRJC), there is an inherent risk of injury. I understand that such injuries could cause permanent disability such as paralysis, permanent bone or joint injury, injury to the musculoskeletal system, other chronic disability conditions, brain injury, and even death. I assume responsibility for any injury sustained by my participation in intercollegiate athletics.

By signing below, I accept the responsibility for reporting ALL injuries and illnesses to the Santa Rosa Junior College Athletic Training staff; including but not limited to, all signs and symptoms of concussions.

Signature of Student-Athlete (or parent or guardian, if a minor) **Date**

CONSENT TO TREAT

I authorize the school or school representative to obtain, through a physician or its own choice, any emergency care that may become necessary while participating in or traveling under the Santa Rosa Junior College's Intercollegiate Athletics Program. I understand the department will perform only those procedures that are within their training, credentials, and scope of professional practice.

I hereby authorize the Certified Athletic Trainers and sports medicine staff acting on behalf of SRJC to evaluate and treat any injury/illness that occurs as a result of my participation in intercollegiate athletics at SRJC. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses.

I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under Medi-Cal care I may not return to participation until I have been given permission by the Team Physician, his/her delegate, or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. The team physicians of SRJC have the FINAL authority regarding participation status following injury/illness.

By signing below, I attest that I understand that I may be injured while participating in intercollegiate athletic activities at Santa Rosa Junior College. I hereby authorize the Santa Rosa Junior College Athletic Training Department and affiliated clinicians and providers to render care that they deem necessary to my health and safety. I authorize the Santa Rosa Junior College Athletic Training staff to evaluate injuries and illnesses that may occur as a result of my participation. I authorize the Santa Rosa Junior College Athletic Training staff to provide preventative, first-aid, rehabilitative, or emergent care deemed necessary for my health and safety.

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training clinic.

Signature of Student-Athlete (or parent or guardian, if a minor) **Date**

SANTA ROSA JUNIOR COLLEGE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Santa Rosa Junior College has always had privacy and patient confidentiality standards in place to ensure appropriate access or disclosure of protected personal and health information. Federal and state laws now provide additional safeguards for ensuring that your health information is adequately protected. In accordance with these laws, Santa Rosa Junior College provides you with a Notice of Privacy Practices (Notice) which explains how your protected information may be used and disclosed in addition to explaining your rights related to your protected information. Since we don't know what services a given patient might be seen for, all student-athletes are provided with a link to the full notice, which may be read at https://admissions.santarosa.edu/annual-notification-students. Notice explains how Santa Rosa Junior College may use and disclose your protected health information to carry out treatment, payment for services, and health care operations. Other reasons to use and disclose your protected health information as permitted or required by law are also referred to in the Notice. The Notice also explains your rights to review and control your protected health information and explains the responsibility Santa Rosa Junior College has to protect your information.

The Santa Rosa Junior College Athletic Training Department adhere to all state and federal regulations in regards to protecting the privacy of your personal and health information.

By signing below, I acknowledge that I have been informed of my rights to privacy. I further acknowledge that my health information, as it pertains to intercollegiate participation, may be disclosed as permitted by law to members of the Santa Rosa Junior College Athletic Training Department and affiliated clinicians and providers, to my coaches, and to pertinent administrators of the Athletic Department. I authorize the disclosure of this information. This may include but is not limited to: medical history, record of injury/illness, progress notes, rehabilitation results, and current medications. I understand this information may be pertinent to the decision of participation, referrals, and recovery.

Signature of Student-Athlete (or parent or guardian, if a minor) **Date**

SECONDARY ATHLETIC INSURANCE

The student-athlete's primary health insurance company will be responsible for any medical related expenses that the student-athlete may incur due to participation in intercollegiate athletics at Santa Rosa Junior College. However, there is a secondary accident/injury insurance plan carried by the Santa Rosa Junior College District. This plan exists to assist in the payment of medically necessary services in excess of the coverage of their primary insurance; meaning this plan is used secondarily to any personal medical insurance coverage of the student-athlete or parents/guardians. The student-athlete is expected to understand that bills received for services rendered will first utilize their individual insurance and anything above and beyond their individual policy coverage will be submitted to the Santa Rosa Junior College's accident/injury insurance.

SRJC reserves the right to void coverage should the student-athlete not report the injury in a timely manner or if the student elects medical treatment (except in the case of an emergency) that is not provided by the Santa Rosa Junior College Sports Medicine Staff.

By signing below, I acknowledge that I have read and understood the Secondary Athletic Insurance Policy. I have asked for clarification if needed. I understand my health insurance is the primary policy responsible for financial obligations and that there are certain limitations in the SRJC accident/injury insurance plan.

Signature of Student-Athlete (or parent or guardian, if a minor) **Date**