

**Old Dominion University Community Care  
Consent for Minor in School  
Parent Permission Form**

*Confidential information to be completed by parent in ink.*

Child's Name \_\_\_\_\_ Child's SSN # \_\_\_\_\_  
(Last) (First) (MI)

Child's Address \_\_\_\_\_  
(City/State) (Zip Code)

Home Phone # \_\_\_\_\_ Guardian's Phone Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Child's Date of Birth \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Race \_\_\_\_\_ Primary Language \_\_\_\_\_

Name of Parent(s)/Legal Guardian(s) \_\_\_\_\_

Address \_\_\_\_\_ Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_ Relation to Student \_\_\_\_\_

Student's Primary Care Doctor \_\_\_\_\_ Ph # \_\_\_\_\_

Student's Dentist \_\_\_\_\_ Ph # \_\_\_\_\_

Does your child have health insurance? NO  YES   
IF YES, please circle: MEDCAID PRIVATE TRICARE

Is the Student currently receiving any **medication/medical treatment** on a continual basis? Y \_\_\_\_\_ N \_\_\_\_\_  
If YES, please specify type of treatment/medication and the physician involved:

\_\_\_\_\_

Please list all **ALLERGIES** to food, medicine, etc. that the student may have:

\_\_\_\_\_

**Consent to Disclose Records:** Records maintained by the Public Schools are considered "education records" and, as such, are governed by the Federal Family Educational Rights and Privacy Act ("FERPA"). The purpose of this consent is to obtain permission, in accordance with FERPA, from the student's parent, legal guardian, or the Student, if the Student is 18 years or older, for the disclosure of the Student's education records related to those health care services provided by ODU Community Care.

**By my signature below, I hereby request and authorize the ODU Community Care to:**

- (1) **release information related to health care services provided to the Student to the appropriate third-party payor for payment purposes; and**
- (2) **exchange information pertaining to the Student's School Entrance Health Form, and related immunizations and school entrance physicals, for the purposes of fulfilling the Commonwealth of Virginia's immunization compliance requirements.**

Print the Student's name: \_\_\_\_\_  
(Last) (First) (MI) (Date of Birth)

**Consent to Treatment:** The purpose of this consent is to obtain permission from the Student's parent or legal guardian for the provision of health care services, including evaluation and treatment by a licensed healthcare provider who may be overseeing a healthcare student. Except in those limited situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent, ODU Community Care must have a written, signed consent from a parent or legal guardian prior to providing health care services to the Student.

**By my signature below, I hereby request and authorize that the Student may:**

- (1) receive health care services available from, and deemed necessary by, ODU Community Care, which services may include, but shall not be limited to, the administration of medication, treatment of acute illnesses and injuries, wellness check-ups, and immunizations;
- (2) receive referral care and emergency transportation to other health care providers, as deemed necessary by the ODU Community Care;
- (3) I have received a copy of the "Notice of Privacy Practices" from ODU Community Care.

**Consent for Telehealth Services:** Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or specialist. The information may be used for diagnosis, therapy, follow-up, and education. It may include sharing of the patient medical record, medical images, live two-way audio and video and output data from medical devices that include sound and video files.

**By my signature below, I hereby request and authorize the ODU Community Care to:**

- (3) release information related to health care services provided to the Student to the appropriate third-party payor for payment purposes; and
- (4) exchange information pertaining to the Student's School Entrance Health Form, and related immunizations and school entrance physicals, for the purposes of fulfilling the Commonwealth of Virginia's immunization compliance requirements.

**The above checked consents are authorized for the length of time the Student is enrolled at a Public or County School System. I may choose to withdraw any consents at any time. Any consent withdrawal must be communicated, in writing, to the ODU Community Care. I understand that even if I, as the Student's parent or legal guardian, withdraw consent for the Student to receive health care services at the ODU Community Care, the Student may still seek treatment in those situations where federal and/or state laws allow minors to access and consent to treatment without a parent's or legal guardian's consent.**

Student's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent's/Legal Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_



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