LAS POSITAS COLLEGE

@D7 GhiXYbh <YU`h\ 7YbhYf
3000 Campus Hill Drive, Livermore, CA 94551
(925) 424-1830

Stanford HEALTH CARE ValleyCare

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This form authorizes the LPC Student Health Center to provide 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 Health Center staff from sharing information about the below named student with anyone other than the student, regardless of age. Information and records pertaining to said student are confidential. This form only needs to be completed once while the student remains a minor. This form may be resubmitted if information needs to be amended.

Please 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 named on this form turns 18 years of age.

STUDENT INFORMATION

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

KNOWN HEALTH CONDITIONS

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

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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

I hereby authorize my above-named child to receive medical care at the Las Positas College Student Health Center.

G][bUhifY cZ DUfYbh#; iUfX]Ub:______________________________ Date:__________

In the event of a medical emergency, my signature above authorizes Las Positas College to seek medical attention for the student named on this form.

STAFF USE ONLY | Received by: ____________________ | Date: ____________

TR 11/5/18