James Morehouse Project

(formerly the ECHS Community Project)

El Cerrito High School – Room A210 – Phone: 510.524.8252

PARENTAL CONSENT
FOR ENROLLMENT IN COUNSELING/YOUTH DEVELOPMENT SERVICES

Dear Parent/Guardian -- Your signature below signifies that you want your child to be able to receive the following services through the James Morehouse Project, a school-based health center located at El Cerrito High School:

- Counseling – individual and group support
- Health/nutrition education and wellness services
- Youth Development activities – including arts, creative movement/expression, action, and more

GENERAL MEDICAL CARE CONSENT: I, as the client/patient (or parent/guardian), hereby authorize professional staff members to provide necessary and/or advisable support for me (or my child).

TEACHING PROGRAM: I understand that this health center is associated with teaching institutions and that some services may be provided by interns/trainees, under the supervision of professional staff.

COLLABORATIVE PROGRAM: I understand that this health center is a collaborative among many different agencies (including, but not limited to: the James Morehouse Project, Brookside Community Health Center, WCCUSD, YMCA of the East Bay, various university social work programs, and other community agencies) and that staff/interns from these various programs may be a part of my health care team.

INSURANCE AND ASSIGNMENT: I understand that if the client/patient has health insurance, this health center may bill that insurance provider for services rendered to the client/patient, and that I will **not** be billed for services provided.

STUDENT INFORMATION

STUDENT NAME: ____ ____
LAST NAME FIRST NAME

HOME PHONE: (_____)______________________ STUDENT CELL:(____)______________________ DATE OF BIRTH: ______________

INSURANCE INFORMATION: DO YOU CURRENTLY HAVE HEALTH INSURANCE? ____NO ____YES
IF YOU CHECKED "YES," PLEASE FILL IN INFORMATION BELOW:

☐ MEDI-CAL ID #_____________________________ ☐ OTHER INSURANCE: ____
(NAME OF OTHER INSURANCE CO.)

☐ HEALTHY FAMILIES ID #_________________________ POLICY #________________________ GROUP # _______________

NAME OF INSURED:___________________ INSURED'S DOB:________

SIGNED: ____ ______/_______/_________
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

____ ______/_______/_________
STUDENT SIGNATURE DATE

Please turn form over to complete family and emergency information on the other side →→→

PARENTAL CONSENT
FOR ENROLLMENT IN COUNSELING/YOUTH DEVELOPEMENT SERVICES (continued)

STUDENT NAME: ______________________________ ______________________________ _____________
LAST NAME FIRST NAME DATE OF BIRTH

FAMILY INFORMATION

PARENT #1: ____ ________________________ ____________________
PARENT/LEGAL GUARDIAN LAST NAME FIRST NAME RELATIONSHIP TO STUDENT

PHONE: HM (____)___________________ CELL(____)____________________ WRK: (____)_____________________

PARENT #2: ____ ________________________ ____________________
PARENT/LEGAL GUARDIAN LAST NAME FIRST NAME RELATIONSHIP TO STUDENT

PHONE: HM (____)___________________ CELL(____)____________________ WRK: (____)_____________________

EMERGENCY INFORMATION

THIS IS THE PERSON YOU WANT US TO CALL IN AN EMERGENCY IF WE ARE UNABLE TO REACH PARENT #1 OR #2:

EMERGENCY CONTACT: ______________________________ _________________________ _____________________
LAST NAME FIRST NAME RELATIONSHIP TO STUDENT

PHONE: HM (____)___________________ CELL(____)____________________ WRK: (____)_____________________

STUDENT'S CURRENT DOCTOR: ____
STUDENT'S PEDIATRICIAN OR REGULAR DOCTOR & NAME OF PRACTICE (IF APPLICABLE)

PHONE: OFFICE # (_____)__________________________ URGENT CARE #: (_____)_________________________

STUDENT MEDICAL INFORMATION: PLEASE PROVIDE THE FOLLOWING IN CASE OF EMERGENCY:

LIST ANY KNOWN DRUG ALLERGIES:____

LIST ANY KNOWN FOOD ALLERGIES:____

LIST ANY PRESCRIBED MEDICATIONS/DRUGS TAKEN REGULARLY:_______________________________________

DOES THE STUDENT HAVE ANY OF THE FOLLOWING CONDITIONS (CHECK ALL THAT APPLY):

- SEIZURES
- ASTHMA
- DIABETES
- OTHER:__________________________________