# Student Services Health Clinic Form

I give my consent for _____to receive health care services provided by the staff of the Student Health Clinic while he/she is a student at Mount Anthony High School. Services available at the clinic include but may not be limited to:

Physical exams (sports, work, routine)
Various lab tests
Routine immunizations
Evaluation and treatment of acute illness
Nutrition and weight counseling
Counseling for school and personal problems
Alcohol and drug counseling
Tobacco cessation

I give permission for my son/daughter to receive nicotine replacement therapy as prescribed by the physician_____.
Parent/Guardian signature

I give permission for my son/daughter to receive gynecological/STD evaluations without my notification_____.
Parent/Guardian signature

I understand that every effort will be made to coordinate care given with our regular family doctor. I give permission to the clinic to receive and send medical information with our primary care provider.

The staff at the clinic considers parental involvement highly important. Accordingly, the staff at the clinic encourages every student to include his/her parent /guardian in medical care decisions and counseling, particularly when prescriptions are given. Parents are encouraged to call the clinic at any time.

Signature_____ Date_____
Parent/Guardian