

## Parent/Guardian Minor Student Authorization Form

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.

**STUDENT INFORMATION**

STUDENT'S LAST NAME	FIRST NAME	MIDDLE INITIAL	STUDENT I.D.# (Social Security # or College ID #, NOT High School #)	
			<b>W#</b>	or <b>SSN:</b> _____ - _____ - _____
ADDRESS			PHONE NUMBER	EMERGENCY NUMBER
CITY	STATE	ZIP	EMAIL ADDRESS	
DATE OF BIRTH			GRADE LEVEL: <input type="checkbox"/> 10th grade <input type="checkbox"/> 11th grade <input type="checkbox"/> 12th grade	

.....  
Print name of Parent/Guardian

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

**Print name of Parent/Guardian:** \_\_\_\_\_ **Phone number:** \_\_\_\_\_

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

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

## PARENT/GUARDIAN INFORMATION

LAST NAME	FIRST NAME	MIDDLE INITIAL	<input type="checkbox"/> HOME or <input type="checkbox"/> CELL NUMBER	
ADDRESS			WORK PHONE NUMBER	
CITY	STATE	ZIP	EMAIL ADDRESS	