

**ARLINGTON MEMORIAL HIGH SCHOOL
FREE STUDENT HEALTH CLINIC
PARENTAL/GUARDIAN CONSENT FOR HEALTH SERVICES**

This form will remain in effect the entire time the student is enrolled at AMHS or until the parent/guardian notifies the Health Office in writing that the consent is to be terminated.

1. 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 Arlington Memorial Middle/High School. Services available at the school will include, but may not be limited to:
- Physical exams (routine health maintenance, sports, work, camp, etc)
 - Various lab test
 - Routine Immunizations
 - First Aid
 - Evaluation and treatment of acute illness
 - Nutrition and weight counseling
 - Health education
 - Counseling and referral for school and personal problems

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

I authorize the release of any medical information necessary to process any insurance claims to my designated insurance carrier and make payment directly to the Arlington Family Practice/Arlington School Health Clinic for the financial support of the clinic.

Signature: _____ Date: _____

2. I also give my permission for my son/daughter to receive the following confidential health services without my notification:
- Evaluation, counseling and treatment for alcohol and drug issues.
 - Evaluation, counseling, and treatment for mental health issues.

I give my permission for my daughter/son to receive evaluation and/or counseling by the School Student Assistant Counselor.

Signature: _____ Date: _____

Issues regarding pregnancy and sexually transmitted disease education, treatment and prevention are protected by Vermont State law and are always considered confidential and **do not** require parental permission.