

**Las Positas College Student Health Center
ValleyCare Health System
3000 Campus Hill Drive, Livermore, CA 94551 9797
(925) 424 1830**

Parent/Guardian Authorization Form for Minors

This authorization will permit your minor child to use the services provided at the Student Health Center. *Note that the Student Health Center providers are bound by confidentiality even though they are treating minors.*

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

PRINT

Student Name _____ **Date of Birth** ___/___/___

As the parent/guardian, do you know of any medical problems we should be aware of for this student?
(Heart disease, mental disorder, allergy to medications, etc.)

PRINT

Parent/Guardian Name _____

Home Address _____

Mailing Address _____

Home Telephone # (____) ____ _____

Work Telephone # (____) ____ _____

I declare under penalty of perjury under the law of the State of California that the foregoing is true and correct.

Parent/Guardian Signature

Date

Please Note:

This declaration does not affect the right of the minor's parents or legal guardian 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 is not valid for more than one year after the date on which it is executed.