Woolley Wellness Center
Consent for Health Care Services

Woolley Wellness Center (WWC) located at Sedro-Woolley High School must have a signed consent from a parent or legal guardian before providing health care services to youth, except in situations where federal and/or state laws allow youth to access and consent to treatment without parent/guardian consent.

I hereby request and authorize WWC, and its physicians, health care professionals, personnel, and staff (collectively, "WWC Staff") to provide to:

Print Youth's Name: ____ ____________________
First Name Middle Initial Last Name Birth Date

such health care services available from and deemed necessary or advisable by the WWC Staff. Health care services may include, but are not limited to, well-teen care procedures, evaluation and treatment of acute illness and injuries, immunizations, blood studies, photographs and X-rays. I further authorize referral of the youth's care and transportation to other physicians, health care professionals, hospitals, clinics, or health care agencies if deemed necessary or advisable by the WWC Staff.

I acknowledge that I have received PeaceHealth Notice of Health Information Practices that describes how health information may be used and disclosed. I understand that when the youth receives health care services at WWC for those situations where federal and/or state laws allow the youth to consent to treatment without parent/guardian consent, all information related to such care will be kept confidential except in the following circumstances:

- The youth permits release of information through a signed authorization.
- The youth exhibits a risk of imminent harm to self or others.
- The youth has a life-threatening health problem and is under 18 years old.
- There is reason to suspect abuse or neglect.
- Certain communicable diseases must be reported to public health authorities.
- Other disclosures as required by law.

This consent is authorized for such time the youth is enrolled at Sedro-Woolley High School. I understand that I may choose to withdraw this consent at any time by writing to WWC. I understand, however, that even if I as parent/ guardian withdraw consent for the youth's health care services, the youth may still seek treatment at WWC in situations where federal and/or state laws allow youth to access and consent to treatment without parent/guardian consent

Youth Signature:____ Date: ____________

Parent/Guardian Signature:_________________________________ Date: ____________

Print Name of Parent/Guardian (and Guardian's relationship): ____________________________________

Parent/Guardian Address: ____

Daytime telephone: ________________________ Evening Telephone: ________________________