

GCH Campus Clinic

Parent/Student Consent Form

Studen	nt Last Name:		First Name:	МЫ ҒЫ
Age:	Date of Birth:	Grade:	Phone Number:	
Addres	ss:		Zip Cod	le:
School	l: Pa	rent/Guardian name:		
Ethnici	ity: Hispanic or Latino? Yes 🛭 N	lo 🗆		
Race:	☐ American Indian or Alaska Nat	ive 🛮 White/Anglo	☐ Asian ☐ Black, African An	nerican
	☐ Unknown ☐ Other (please s	pecify)		
Preferr	ed Language:			
Your in	surance may be billed for this servi to pay.	ce. No student needi	ng care will be turned away due	to lack of health insurance or
Please	list student insurance information:	:		
□ Insu	rance:	number:		
□ Non	e			
Does s	tudent have a Primary Care Provide	er? □ Yes □ No Na	ame	Phone
Known	Allergies? ☐ Yes ☐ No. If yes, ple	ase explain:		
manag and to staff to includi	e permission for my child to receive tement and/or dental care and for Gask and receive information from the consult with and provide information gschool health professionals, and of Privacy Practices is available up	GCHCC staff to access ne school about stude ion and records to oth d for purposes of prog	s my student's class schedule (ent's health history. This includ er healthcare, mental health pr	for appointment purposes only es permission for the GCHCC oviders, dental providers,
□Ido	not give permission for my child to	o receive GCHCC serv	rices	
	(New Mexico law allows for some	services without pare	ental consent)	
Parent	t/Guardian Signature:		Daytime Phone:	Date:
Emerge	ency Contact:		Daytime Phone:	
Studen	nt Signature (18 vrs and older):		Daytime Phone:	Date: