

Welcome to Delta Health Care Teen Services

Dear Parent,

Please sign the consent form below and return it to the school. The consent form ensures that your child receives the services he/she might need from the Delta Health Care staff through the school-based health centers. Services are free to students and are conducted by licensed medical personnel.

If you have any questions about this form or our services, please call 444-8300. Office hours are Monday through Friday, 7:30am to 3:30pm. Thank You.

Permission for Sports Physicals

STUDENT NAME: _____
(Please Print) Last First Middle Initial

ADDRESS: _____ ZIP CODE _____

PHONE: _____ DATE OF BIRTH: _____

MEDICAL INSURANCE: _____

SCHOOL CURRENTLY ATTENDING: _____

I certify that I am the parent/guardian of the student listed above. I give my permission for the above named student to participate in a sports physical examination conducted by Delta Health Care medical staff.

This consent shall remain in effect for as long as this student is enrolled in Stockton Unified School District. I understand that I may withdraw my consent at any time by submitting a signed and dated waiver revoking my consent. I further authorize the release of information regarding treatment: 1) to third-party payers, such as MediCal or insurance, for billing purpose, 2) to necessary school and other related collaborative agency personnel, 3) as otherwise mandated by law.

Name of Parent/Guardian: _____ Relationship: _____
(Please Print)

Parent/Guardian Signature _____ Date _____ Emergency Daytime Phone Number: (____) _____

Student's Signature _____ Date _____