Title: 
Treatment of Minors or Persons Under Guardianship

Adopted: 1/00

Number: Bylaws 0033

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Approved By: Wende Hargrove, Health Services Coordinator; Dr. Neil Speth, Medical Director; Kaylene Hallberg, Dean of Student Services; Stephanie Ortiz, Dean of Nevada County Campus

Distribution: Health Services Rocklin and NCC

Reference(s):

Purpose:

To provide staff with procedures to ensure compliance with legal requirements relative to the treatment of minors and persons under guardianship.

Procedure:

Minors (under age 18) and those under guardianship will not be treated without proper consent unless they are emancipated. A legal guardian, as personal representative, will be required to sign consent for medical treatment and HIPAA notification acknowledgement on the New Patient Data Form before a minor will be treated at Sierra College Health Services. See attached Consent for Medical Treatment.

A. Emancipated Minor meets the following requirements

1. Is married; or
2. Is on active duty for the Armed Forces
3. Meets the following requirements:
   a. The minor is at least 15 years of age
   b. Minor willingly lives separate and apart from his parents or guardian with or without the consent of the parent or guardian.
   c. The minor is managing his own financial affairs regardless of the source of the minor’s income.
4. Legal documentation of emancipated status must be provided.

B. STD and Family Planning

Family planning and STD treatments may be rendered without parental or guardian consent.

C. Immunizations and Routine Medical Care

Patients under 18 years must have a signed parental consent.

Emergency Care

Life sustaining emergency care for minors will be provided. Parental or guardian consent will be sought as soon as possible.

For minor emergencies (i.e. lacerations requiring stitches and Tetanus booster), telephone consent will be obtained.

Tuberculosis Screening

Patients under 18 years must have a signed parental consent.
PARENTAL/GUARDIAN CONSENT FOR MEDICAL TREATMENT

Sierra College Health Services (SCHS)

Student Name __________________________ Date of Birth __________________

SSN __________________________ Today’s Date __________________

Parent Information:
Name __________________________

Address __________________________ City __________ State __________ Zip Code
Home phone ( ) Work phone ( ) Cell phone ( )

Emergency Contact:
Name __________________________ Relationship to Student __________________
Address __________________________ City __________ State __________ Zip Code
Home phone ( ) Work phone ( ) Cell phone ( )

Consent:
I, __________________________ (parent/guardian) do hereby authorize a representative of Sierra College to provide:

____ Immunizations
____ Medical treatment regarding __________________________ (list symptoms or general problem)
____ Urgent treatment for __________________________ (list injury or problem)
____ Tuberculosis surveillance
____ All medical treatment within scope of services at SCHS

Parent/guardian signature __________________________ Date __________

Telephone Consent:
Date __________

Medical Provider __________________________ Print name and title __________________________ Signature

Witness __________________________ Print name and title __________________________ Signature