CONSENT FORM
California Child Health & Disability Prevention Program

I hereby give my consent for _____
(NAME OF PATIENT)

to receive the health screening tests and immunizations recommended by the CHDP Program. I hereby authorize release of information concerning the results of these screening tests to CHDP Program personnel. I also authorize release of the information to the locations checked below. I understand that information provided to CHDP Program personnel will be strictly confidential and will be used only to make the provision of health services easier and to permit statistical reporting on the results of screening.

(Check box)

☐ School _____
NAME

_____
ADDRESS

_____

☐ Health Care Provider _____
NAME

Santa Lucia Medical Group
1336 Natividad Rd
Salinas, CA 93906
PH# (831) 754-4444

☐ Other _____
NAME

_____
ADDRESS

_____ _____
SIGNATURE OF PARENT, GUARDIAN, OR EMANCIPATED MINOR DATE

_____
NAME OF PARENT, GUARDIAN, OR EMANCIPATED MINOR

Screening Provider: This form signed by parent, guardian, or emancipated minor must be retained in patient's file.