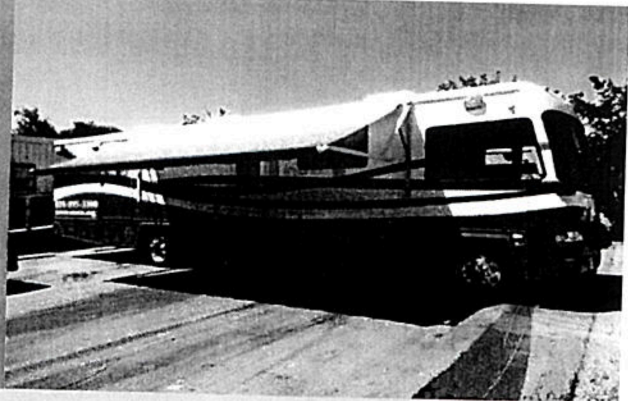
Mission City Community Network, Inc.



A Community Health Network

MCCN San Fernando Valley Mobile Clinic

CESAR E. CHAVEZ LEARNING ACADEMIES

"Clinic on Wheels (COW)"

Tech Prep Academy (TPA)
Social Justice Humanitas Academies (SJHA)
Art Theater Entertainment School (ARTES)
Acedemy of Scientific Exploration (ASE)

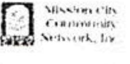
Every 2nd & 4th Wednesday ; 8:30 AM – 4 PM
1001 Arroyo Ave., San Fernando CA 91340

Programs and Services

- Physical Examinations (General & Sports Physicals)
- Diagnosis and Treatment of Minor and Acute Illnesses and Minor Injuries
- Women's Health (Pregnancy Testing & Referral for Prenatal Care)
- Dental Services (Screenings, Treatment, Fluoride and Varnish, Fillings and Examinations)
- Mental Health Services
- Hearing Screening
- Vision Screening
- Immunizations/Vaccination

Mission City Community Network (MCCN) is a full service non-profit community clinic offering a wide range of services to meet the needs of the community we serve.
MCCN Mission Statement: To provide, advocate and model quality health care and social services for the uninsured and low income families in communities of Southern California.

For More Information and Appointment:
Please See Your School Nurse
Or Call : 818-837-6250 / (818) 895-3100



Parent/Legal Guardian Consent Form

NAME OF STUDENT	GRADE	TRACK
HOME ADDRESS	CITY	ZIP
DATE OF BIRTH		HOME PHONE
NAME OF PARENT/LEGAL GUARDIAN		PARENT/GUARDIAN PHONE

Students who are over 18 years of age may consent for their own services. Certain other services may be available to minors (children <18 years) without parental consent.

Is the student covered by health insurance or some other kind of health care plan? ☐ Yes ☐ No

If yes, please complete the section below.

Medi-CAL/ INSURANCE CARD NUMBER:	SS# if you don't know your Insurance Card Number:	
Health Insurance or Health Coverage Plan:	Name of Medical Provider or Clinic:	Provider Phone #:

Please check all services you agree to have your student to receive at Mission city Community Network:

MEDICAL SERVICES

☐ Physical examinations (General , sports physical, etc.)	☐ Family planning services, including examinations and contraceptive methods.	☐ Prescriptive and over-the-counter items, including psychiatric medicine.
☐ Vision and hearing screenings	☐ Pregnancy testing and referral for prenatal care.	☐ Diet and weight control programs
☐ Diagnosis and treatment of minor and acute illnesses	☐ Assistance with chronic (ongoing) illnesses, such as, asthma, diabetes, epilepsy.	☐ Alcohol and other drug abuse counseling and referral.
☐ Immunizations	☐ First Aid of minor injuries.	☐ Psychological Services
☐ Treatment of acne and other skin problems.	☐ Laboratory services.	☐ HIV testing and counseling.
☐ Diagnosis and treatment of sexually transmitted diseases.	☐ Limited x-ray services at Mission City Community Network.	☐ Referrals for health services which cannot be provided at the School Based Health Center. ☐

DENTAL SERVICES

☐ Dental Screening Exam	☐ X-rays	☐ Fillings
☐ Cleanings	☐ Fluoride	☐ Varnish/Gel

I/We understand that this consent covers only those services provided at this clinic or another MCCN site that result from a request from the parent/guardian or student, or from a referral made by school personnel to the Mobile Medical/Dental Clinic Center, and does not authorize services rendered by or at any other private or public facility.

I/We understand that MCCN is not a part of the regular and ongoing program of the school or the Los Angeles Unified School District (LAUSD), and the services provided are not LAUSD or school-sponsored activities or programs. The services are made available at the school/site for my convenience to obtain medical, mental health and oral health services for my child. I/We understand that the LAUSD does not assume responsibility for the services provided by MCCN.

I/We hereby authorize a physician and other Professional Clinic staff to provide necessary and/or advisable treatment for my son/daughter. This student has my/our permission to receive all services offered at the Mobile Medical/Dental Clinic EXCEPT those that I have specifically excluded above.

I/WE understand that I can revoke this consent at any time either by calling the Mission City Clinic staff or by submitting a request I writing to Mission City clinic staff.

I/We understand THAT NO STUDENT WILL BE CHARGED DIRECTLY FOR SERVICES. All third party payment sources accessible to the student will be billed. Should you desire that your child use Mission City as his/her medical home, you will be asked to formally select a Mission City provider with Medi-Cal or other appropriate insurers. Medical Records will be kept in a secure and confidential manner; however, I/We acknowledge that the Mobile Medical/Dental Clinic (MCCN) may release information regarding treatment to third-party payers, such as Medi-Cal or insurance companies for the purpose of billing. I/We also understand that public information such as immunization history or illnesses that constitute a public health hazard may be shared with the school nurse, or with the public health department to protect the health of other students and the public in accordance with the California Health and Safety code.

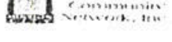
I/we have read and understand that in order for MCCN to provide a referral, the patient must be assigned to one of the Mission City Community Network clinics as the patient's medical home. If the patient is not assigned to MCCN the patient must change their medical home to MCCN. Once the patient switches to MCCN they will be linked to a medical home at one of our clinic sites.

I/we have read and understand that if a patient chooses not to change medical homes, MCCN will refer patient to their primary care who can then refer them to specialist for follow treatment and diagnostic treatment.

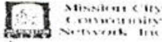
I/we have read and understand that if the patient is assigned to MCCN, and such initial screening/treatment services (or subsequent examinations) indicate the need for Referral Services, MCCN agrees to assist MCCN patients in making timely and appropriate appointments with the Referral Provider for the provision of referral services.

I/We understand that this consent is good for one year (12 months) from the date of the signature below.

SIGNATURE OF PARENT/LEGAL GUARDIAN:	RELATIONSHIP TO STUDENT:	DATE:
ADDRESS OF PARENT/LEGAL GUARDIAN (IF DIFFERENT FROM ABOVE):		
SIGNATURE OF STUDENT:		
MY STUDENT MAY BE SEEN WITHOUT A PARENT/GUARDIAN PRESENT? ____ YES ____ NO		
OFFICE USE ONLY		
SIGNATURE VERIFIED BY:		DATE



Formulario de consentimiento de padre/ guardian legal



NOMBRE DEL ESTUDIANTE	AÑO ESCOLAR	CURSO (TRACK)
DIRECCION	CIUDAD	CODIGO POSTAL
FECHA DE NACIMIENTO		NUMERO DE TELEFONO DEL HOGAR
NOMBRE DEL PADRE O TUTOR LEGAL		NUMERO DE TELEFNO DEL PADRE/TUTOR

ESTUDIATES MAYORES DE 18 ANOS TIENEN DERECHO A CONSENTIR SUS PROPIOS SERVICIOS. OTROS SERVICIOS ESTAN DISPONIBLE A MENORES (ADOLECENTES <18 ANOS) SIN CONSENTINIENTO DEL PADRE/TUTOR

¿ESTA EL ESTUDIANTE CUBIERTO POR UN SEGURO DE SALUD U OTRO TIPO DE SEGURO? ____ Si ____ No

Si es sí, por favor llene la sección de abajo.

NUMERO DE ASEGURANZA:	Indique su seguro social si no tiene su numero de medical:	
COBERTURA DE SALUD:	NOMBRE DEL PROVEEDOR O CLINICA MEDICA:	NUMERO DE TELEFONO DEL PROVEEDOR :

POR FAVOR MARQUE TODOS LOS SERVICIOS EN LOS QUE ESTE DE ACUERDO A QUE SU ALUMNO RECIBA EN MISSION CITY COMMUNITY NETWORK

SERVICIOS MEDICOS

☐ Examen físico	☐ Servicios de planificación familiar, incluyendo examen medico y métodos anticonceptivos	☐ Medicamento recetado o de venta libre, incluyendo Medicina psiquiátrica
☐ Examen de la vista y audición	☐ Pruebas de embarazo y referencia medica para cuidado prenatal	☐ Programas de nutrición y control de peso
☐ Diagnostico y tratamiento de enfermedades agudas	☐ Asistencia con enfermedades crónicas, coma asma, diabetes o epilepsia.	☐ Consejería y referencia para el abuso de alcohol y drogas
☐ inmunizaciones	☐ Primeros auxilios para lesiones menores	☐ Servicios psicológico
☐ Tratamiento de acné y otros problemas de la piel	☐ Servicios de laboratorio	☐ Prueba y consejería de HIV
☐ Diagnostico y tratamiento de enfermedades de transmisión sexual	☐ Servicios limitados de Rayos X en Mission City Community Network	☐ Referencia para servicios no disponibles en el Centro de salud Escolar

SERVICIOS DENTALES

☐ Consulta y Examen	☐ Rayos X	☐ Rellenos
☐ Limpieza	☐ Aplicar fluoruro	☐ Barniz/Gel

Yo/nosotros entiendo que este consentimiento cubre sólo los servicios en esta clínica u otro sitio de MCCN que resulte de una solicitud de los padres o estudiante, o de un referencia hecha por el personal de la escuela al centro de la clínica móvil medica/dental, y no autoriza servicios prestados por o en cualquier otras instalaciones privadas o publicas.

Yo/nosotros entiendo que MCCN no es parte del programa de la escuela regular y curso o del distrito de las Escuelas Unificadas de Los Ángeles (LAUSD), y los servicios no son patrocinados por LAUSD o programas o actividades de la escuela. Los servicios están disponibles en la sitio de la escuela para mi conveniencia para obtener servicios de salud mental y salud y dentales para mi niño. Yo entiendo que LAUSD no asume responsabilidad por los servicios proveídos por MCCN.

Yo/nosotros autorizo a un médico y otro personal profesional de la clínica a proporcionar tratamiento necesario o recomendable para mi hijo. Este estudiante tiene mi/nuestro permiso de recibir todos los servicios ofrecidos en la clínica móvil médica/dental excepto los que específicamente he excluido arriba. Yo/nosotros entiendo que puedo revocar este consentimiento en cualquier momento llamando al personal de Mission City o presentando un solicitud escrita a al personal de Mission City.

Yo/nosotros entendiendo que NINGUN estudiante se le va a cobrar directamente por los servicios. Todas las fuentes de pago del tercer partido accesibles al estudiante se le facturaran. Si usted desea que su niño utilice Mission city como su clinica medica, se le pedirá que seleccione formalmente un proveedor de Mission City con Medi-Cal u otros seguros apropiado

Registros médicos serán guardados en una manera segura y confidencial; sin embargo, he reconocer que la clínica móvil médica/dental (MCCN) puede liberar información sobre tratamientos a pagadores terceros, tales como Medi-Cal o seguros médicos para el propósito de facturación. También entendemos que información pública como historial de inmunización o enfermedades que constituyen un peligro público de salud puede ser compartida con la enfermera de la escuela, o con el Departamento de la Salud Publica para proteger la salud de otros estudiantes y el público de acuerdo con el código de salud de California.

Yo/nosotros he leído y entiendo que si un paciente elige no cambiar casa médica, sin embargo, las referencias no serán procesadas (en su lugar, la proveedor documentara recomendaciones en el Resumen de la visita clínica al paciente al final de la cita). Yo/nosotros he leído y entiendo que si la paciente es asignado a MCCN, y tal inicial examen y servicio de tratamiento(o exámenes posteriores) indican necesidad de referencia, MCCN accede a ayudar a pacientes de MCCN en hacer cita oportuna y apropiada con el proveedor de la referencia para la disposición de los servicios de la referencia.

YO/NOSOTROS ENTENDEMOS QUE ESTE CONSENTIMIENTO ES BUENO PARA UN AÑO (12 MESES) DE LA FECHA DE LA FIRMA ACONTINUACION.

FIRMA DE PADRE/TUTOR LEGAL :	RELACION CON EL ESTUDIANTE:	FECHA
FIRMA DEL ESTUDIANTE:		FECHA
DIRECCION DE PADRE/TUTOR LEGAL (SI ES DIREFENTE A LA DIRECCION EL LA SECCION DE ARRIBA)		
MI ESTUDIANTE PUEDE SER VISTO SIN UN PADRE O TUTUR PRESENTE?		____ SI ____ NO
OFFICE USE ONLY		
SIGNATURE VERIFIED BY		DATE