Guardianship for Minor Applicants Procedures

In order for an eligible international student under the age of 18 to be considered for admission to Irvine Valley College (IVC), the student's parents must appoint a guardian who lives in or within 25 miles of Irvine, California and agrees to take all responsibility for the student until they turn 18.

IMPORTANT: The minor student must live with the appointed guardian until the student turns 18 and the guardian must be physically present at the listed local residence. Should it be found that the minor student is not living with the appointed guardian OR that the appointed guardian is not physically present in the minor's home, the minor student is subject to dismissal from IVC.

Irvine Valley College cannot act in the place of the parent or guardian. In the event of a personal emergency, accident, illness or incarceration, the State of California will require the signature of a guardian before hospitalization or legal counsel can be obtained. If you are under the age of 18, you are required to have your parent submit a signed statement informing Irvine Valley College who will be your appointed guardian.

The Role of the Appointed Guardian:

The appointed guardian has complete responsibility in all issues related to the student while the student is enrolled at Irvine Valley College and/or until the student reaches the age of 18. Such issues in which the appointed guardian is responsible for include, but are not limited to, the following:

- ✔ Living with and being physically present with the student at the local residence
- ✔ Medical care for the student (physical and emotional)
- ✔ Disciplinary issues that may arise at the school
- ✔ Law enforcement/legal issues resulting from the student's conduct
- ✔ Educational concerns related to the student's study at Irvine Valley College
- ✔ Contact with the parents in the home country as needed
- ✔ Acting as a liaison between the student, parent and Irvine Valley College in matters related to the student's study at our institution and stay in the U.S.
- ✔ Submitting the "Health & Wellness Services Informed Consent" form (attached) so that required Tuberculosis (TB) screening tests can be completed.

Requirements to be a Guardian:

The appointed guardian must meet the following criteria to be considered:

1. The appointed guardian must be a US Citizen or Permanent Legal Resident.
2. The appointed guardian must be living in or within 25 miles of Irvine, California.
3. The appointed guardian must be physically present at the residence and live with the minor until such time that the student turns 18 years of age.
4. The appointed guardian must be over the age of 25 *(copy of CA Driver's License required)*
5. The appointed guardian and parent must be available should any problems arise with the student until such time that the student turns 18 years of age.

continued

Process to Establish a Local Guardian:

1. Both the *"Process to Establish a Local Guardian"* and *"Affidavit of Guardianship"* must be completed and signed by the parent of the minor/applicant AND the appointed guardian.
    a. The signature of the parent verifies that they have agreed to appoint a local guardian to be responsible for their child while in the US until such time that the student reaches the age of 18.
    b. The signature of the appointed guardian indicates their understanding that they will live with the minor student, remain physically present at the residence and are responsible for all issues related to the student's life in the US until such time that the student reaches the age of 18.
2. The *"Health & Wellness Services Informed Consent*" is signed and submitted. (Required for mandatory Tuberculosis (TB) screening tests to be administered.
3. A copy of the legal guardian's California Driver's License or California ID card is submitted
4. Once these documents are received, Irvine Valley College will review the minor's application and make a decision for admission.
5. Submission of false information will result in the denial of the application and/or dismissal of the student from IVC.

Should you have any questions about this policy, please contact at (949) 451-5414 or iso@ivc.edu.

My signature below confirms my understanding of and agreement to my role as the appointed guardian for the minor student. My signature below confirms that the student will live in my home that is located in or within 25 miles of Irvine, California and that I will remain physically present in the home until such time that the minor turns 18 years of age. I understand that if at any time it is found that I am not physically present and living with the minor, the student is subject to dismissal from IVC. I understand that in all legal issues, I am and remain responsible for the care and guardianship of this minor student. Irvine Valley College is released from all legal responsibility for the care or well-being of the minor student.

_____ _____
Printed Name of Guardian Signature of Guardian

_____ _____
Printed Name of Minor Student IVC Student ID Number

_____
Date

To be completed by the applicant's parent:

My signature below confirms that I appoint _____ as the guardian for my child.
Name of Guardian

_____ _____ _____
Printed Name of Parent Signature of Parent Date Signed

IRVINE VALLEY COLLEGE | INTERNATIONAL STUDENTS

AFFIDAVIT OF GUARDIANSHIP

(Official US notarization required)

I, _____ residing at
Name of Appointed Guardian (First/Last)

_____ depose and say:
Street Number *Apartment* *City* *State* *Zip Code*

1. That I have agreed to be the legal guardian of _____
Full name of applicant/student (First/Last)

whose date of birth is _____ who is a minor child of school age.
m*onth/day/year*

2. I am a US citizen or Permanent Legal Resident currently residing in California.

3. I confirm that I will live with the minor student and remain physically present at the above address until such time that the student reaches the age of 18. I understand that if at any time it is found that I am not physically present and living with the minor, the student is subject to dismissal from IVC.

4. That I am over the age of 25 and my date of birth is *(copy of CA Driver's License required):* _____
month/day/year

5. That I accept all legal responsibility for _____ in all
Full name of applicant

student matters while enrolled at Irvine Valley College and/or until said minor reaches the age of 18 on _____.
month/day/year

6. I will submit the "Authorization for Irvine Valley College Student Health Services to Consent to Treatment of Minor Lacking Capacity to Consent"

7. My relationship to the applicant/student is _____.

My signature below indicates that I have read the *"Guardianship for Minor Applicants Procedures"* and agree to my role as the guardian for the above student. I understand that Irvine Valley College cannot act in the place of the parent or legal guardian. In the event of personal emergency, accident, illness, incarceration or disciplinary action at the institution, the established guardian and parent will maintain full responsibility for the minor student. Irvine Valley College is released from all liability related to the student's study at the institution.

_____ _____
Printed Name of Appointed Guardian Signature of Appointed Guardian

_____ _____
Telephone Number of Appointed Guardian Fax Number of Appointed Guardian

_____ _____
Email address of Appointed Guardian Date Signed

IRVINE VALLEY COLLEGE
Health and Wellness Center

Health and Wellness Services Informed Consent

Student Name:	**Student ID #:**
Preferred Name/Pronoun:	**Student Telephone #:**

Thank you for choosing the Student Health and Wellness Center (HWC) at Irvine Valley College (IVC) as your service provider. The HWC provides medical, mental health, and wellness services to all enrolled IVC students regardless of their insurance coverage. This informed consent outlines how to access these services, the availability of resources, how providers address medical care and mental health concerns, and the confidentiality of records. By signing this consent, the student permits the HWC team to provide medical, wellness, and/or mental health services.

APPOINTMENTS

IVC students may schedule appointments online at ivc.studenthealthportal.com or call the HWC directly at (949) 451-5221. The student is advised to arrive on time to benefit from their appointment most. Late arrivals may be rescheduled. We ask that students who are unable to attend their appointment notify the HWC at least 24 hours in advance.

MEDICAL CARE SERVICES

The HWC recognizes that a variety of illnesses in the United States have preventable causes. To prevent these medical problems, healthy decisions are encouraged. The HWC offers routine/sports physicals, immunizations, medical consultations, sick illness care, and reproductive services that include but are not limited to birth control, sexually transmitted infections education, testing and treatment, pap smears, and breast exams. Other services include lab testing, medication distribution, and prescriptions.

MENTAL HEALTH SERVICES

Mental health services often lead to an increase in healthy coping skills, improved relationships, and significant reductions in feelings of distress. These services are available and intended to meet the needs of the students. For therapy to be most effective the student will be encouraged to explore topics related to academic barriers, home life, and social support. The HWC therapists are mental health professionals who specialize in, but are not limited to anxiety, healthy relationships, identity exploration, depression, and trauma.

*" Dependent adult" means a person regardless of whether the person lives independently, between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, a person who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age."

They provide a confidential, non-judgmental environment, in a secure and private office. Students are allowed to orient themselves to the therapist and the therapy process.

Mental health services are short-term in nature to help students with problem identification followed by referring students to outside mental health resources for continuation of care as needed. After the initial session, the student and the therapist will determine if the HWC mental health services are the best fit for the student. If it is best for the student to be served by other agencies or professionals, then the therapist will refer the student to the appropriate community or campus resources.

CONFIDENTIALITY

Sessions between mental health therapists, medical healthcare providers, and students are strictly confidential and are not shared with other departments, staff, or faculty on campus, nor is it shared with anyone else without the student's written consent. All documentation taken by the mental health therapist or medical h ealthcare providers during therapy sessions or primary care visits shall not be disclosed to anyone without your written consent, including parent(s), spouse(s), friend(s), and /or college personnel. There are several exceptions to the rule of confidentiality, as mandated by law and proper agencies will be notified of the event/events when:

- Suspicion of abuse:
    - To a child under the age of 18 years old
    - Vulnerable/Dependent Adult*
    - Elderly over the age of 60 years old
- You are in danger of harming yourself and others or causing considerable property damage.
- Experiencing food, shelter, and/or clothing insecurities.
- You use your mental health as a defense in litigation.

EMERGENCY SERVICES

The Student Health and Wellness Center ***does not*** provide crisis or emergency services. Should you need immediate healthcare services, please go to your nearest hospital, or dial 9-1-1 for life-threatening emergencies.

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IRVINE VALLEY COLLEGE
Health and Wellness Center

Health and Wellness Services Informed Consent

STUDENT CONSENT

It is important for students who wish to seek services at the HWC to do the following:

- ☐ Read the Health and Wellness Services Informed Consent and fully understand the contents.
- ☐ Request and provide their consent to medical care/therapy services as described herein.
- ☐ Understand the confidentiality of medical care/mental health services.
- ☐ Understand their rights, limitations, and responsibilities as a recipient of these services.
- ☐ Know that proper conduct and behavior are expected of all who enter the HWC, and Board Policy 5500 *Standards of Student Conduct and Discipline Procedures* applies to all students. Any perceived or demonstrated student misconduct will be documented and sent to the disciplinary officer in a written report detailing the incident. Additionally, the student who showed misconduct may be asked to leave the premises.

MENTAL HEALTH SERVICES ONLY

- ☐ Know that they can end therapy/mental health services at any time by informing their therapist.
- ☐ If the therapist decides that services are not beneficial to the student, they will make the proper referrals for continuation of care. If a student declines the suggested referral, the therapist may limit the number of future sessions.
- ☐ Therapists can end a student-therapist relationship when it is clear the student is no longer benefiting, when services are no longer needed, or when therapy no longer serves the student's needs and/or interests.

By signing below, I acknowledge that I have read and fully understand the terms and conditions outlined in this consent document. I agree to receive medical, wellness, or mental health services from the HWC, abide by the terms and conditions, and follow procedures set forth by the Irvine Valley College Student Health and Wellness Center services.

Student Signature ***(must be over the age of 18 years old to sign)***	**Date:**
Parent/Legal Guardian/ Conservator Signature	**Date**:

**" Dependent adult" means a person regardless of whether the person lives independently, between the ages of 18 and 64 years who resides in this state and who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights, including, but not limited to, a person who have physical or developmental disabilities, or whose physical or mental abilities have diminished because of age."*

IRVINE VALLEY COLLEGE

Health and Wellness Center
5500 Irvine Center Drive, Irvine, CA 92618 | T: 949-451-5221 | F: 949-451-5393 | ivc.edu/hwc

PATIENT INFORMATION FORM

Legal Name:_____ **Student ID:**_____ **DOB:**_____

Preferred Name:_____ **Pronouns:**_____

Sex Assigned at Birth: ○ **Male** ○ **Female** ○ **Intersex** **Birthplace:**_____

Parent/Guardian's Name (if minor):_____

Address:_____ **Phone #:**_____

Email:_____ **Is it ok to send you text messages?** ○ **Yes** ○ **No**

Race: ○ **White** ○ **Hispanic/Latino** ○ **American Indian/Alaskan Native** ○ **Asian**

○ **Black African** ○ **Native Hawaiian/Other Pacific Islander** **Other** _____

Language Preference:_____ **Hearing Impaired:** ○ **Yes** ○ **No Vision Impaired:** ○ **Yes** ○ **No**

Primary Care Physician:_____ **Phone Number:**_____

Pharmacy:_____ **Phone Number:**_____

Do you have insurance? ○ **Yes** ○ **No** **If yes, who is your insurance carrier?**_____

In Case of Emergency, Notify:

Name:_____ **Relationship to Patient:**_____ **Phone:**_____

Patient's Signature:_____ **Date:**_____

Created 10/12/2023rv

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NEW PATIENT MEDICAL HISTORY FORM

Patient Name:_____ **Student ID:**_____

ALLERGIES ☐ NO ALLERGIES

ALLERGY	ALLERGIC REACTION

MEDICATIONS

MEDICATIONS *(Please list ALL)*	DOSE *(Mg., pill, etc.)*	TIMES PER DAY

If you need more room to list medications, please write them on a blank sheet of paper with the required information.

HEALTH MAINTENANCE SCREENING TEST HISTORY

CHOLESTEROL	Date:	Facility/Provider:	Abnormal Result? Y N
COLONOSCOPY/SIGMOID	Date:	Facility/Provider:	Abnormal Result? Y N
MAMMOGRAM	Date:	Facility/Provider:	Abnormal Result? Y N
PAP SMEAR	Date:	Facility/Provider:	Abnormal Result? Y N
BONE DENSITY SCAN	Date:	Facility/Provider:	Abnormal Result? Y N

VACCINATION HISTORY

Last Tetanus Booster or TdaP:	Last Pnuemovax *(Pneumonia)*:
Last Flu Vaccine:	Last Prevnar:
Last Zoster Vaccine *(Shingles)*:	Last COVID-19 Vaccine Booster:
Last MMR Vaccine:	Last Hepatitis B Vaccine:

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PERSONAL MEDICAL HISTORY

DISEASE/CONDITION	CURRENT	PAST	COMMENTS
Alcoholism/Drug Abuse			
Asthma			
Cancer *(type:_____)*			
Depression/Anxiety/Bipolar/Suicidal			
Diabetes *(type:_____)*			
Emphysema *(COPD)*			
Heart Disease			
High Blood Pressure *(hypertension)*			
High Cholesterol			
Hypothyroidism/Thyroid Disease			
Renal *(kidney)* Disease			
Migraine Headaches			
Seizures/Epilepsy			
Stroke:			
Other:			

SURGERIES/HOSPITALIZATIONS

TYPE *(specify left/right)*	DATE	LOCATION/FACILITY

WOMEN'S HEALTH HISTORY

Date of Last Menstrual Cycle:	Age of First Menstruation:	Age of Menopause:
Total Number of Pregnancies:	Number of Live Births:	
Pregnancy Complications:		

Patient's Name:_____ **Student ID:** _____

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FAMILY MEDICAL HISTORY

O **NO SIGNIFICANT FAMILY HISTORY IS KNOWN**

II **CHECK ALL THAT APPLY**	Alcohol/Drug Abuse	Asthma	Cancer (type:)	Emphysema (COPD)	Depression/Anxiety	Bipolar/Suicidal	Diabetes	Early Death	Heart Disease	High Cholesterol	High Blood Pressure	Kidney Disease	Stroke	Thyroid Disease	Migraines	Other:	Other:
Mother																	
Father																	
Brother																	
Sister																	
Child																	
Maternal Grandmother																	
Maternal Grandfather																	
Paternal Grandmother																	
Paternal Grandfather																	

SOCIAL HISTORY

Occupation *(or prior occupation)*:	O Retired O Unemployed O LOA O Disabled
Employer:	Years of Education or Highest Degree:
If employed, do you work the night shift? Y N N/A	
Marital Status *(check one)*: O Single O Partner O Married O Divorced O Widowed O Other:	
Do you have children? Y N	If yes, how many?

OTHER HEALTH ISSUES

TOBACCO USE	Smoke Cigarettes? Y N *(If you never smoked, please move to Alcohol /Drug Use)*		
Current: Packs/day ____ # of Years ____	***Past:*** Quit Date: _____ Packs/day ____ # of Years		
Other Tobacco *(check one)*: O Pipe O Cigar O Snuff O Chew O Vape			
ALCOHOL/DRUG USE	Do you drink alcohol? Y N	O Beer O Wine O Liquor	# of Drinks/week:
Do you use marijuana or recreational drugs? Y N		Have you ever used needles to inject drugs? Y N	
Have you ever taken someone else's drugs? Y N			

Patient's Name:_____ **Student ID:** _____

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OTHER HEALTH ISSUES continued...

SEXUAL ACTIVITY	Sexually involved currently? Y N *(If no sexual history, please continue to Exercise)*	
Sexual partner(s) is/are/have been: □ Male □ Female □ Both Other:		
Birth control method: □ None □ Condom □ Pill/Ring/Patch/Inj/IUD □ Vasectomy		
EXERCISE	Do you exercise regularly? Y N *(If you answered no, please move to Sleep)*	
What kind of exercise?	***Duration:*** How long (min.): _____ How often:	
SLEEP	How many hours, on average, do you sleep at night *(or during the day, if working the night shift)*?	
DIET	How would you rate your diet? □ Good □ Fair □ Poor	Would you like advice on your diet? Y N
SAFETY	Do you use a bike helmet? Y N	Do you use seat belts consistently? Y N
Working smoke detector in the home? Y N		If you have guns at home, are they locked up? Y N
Is violence at home a concern for you? Y N		Have you completed an Advance Directive for Health Care (ADHC), Living Will, or Physical Orders for Life-Sustaining Therapy (POLST)? Y N

OTHER PROVIDERS/SPECIALISTS

SPECIALIST	NAME	LAST VISIT
Cardiology		
Gastroenterologist (GI)		
OB/GYN		
Neurology		
Pulmonary		
Other:_____		
Other:_____		

ADDITIONAL INFORMATION

Have you served in the military? Y N	If yes, how long and what branch?
Were you deployed? Y N	If yes, where?

Patient's Name:_____ **Student ID:** _____

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REVIEW OF SYSTEMS CHECK ALL THAT APPLY

CONSTITUTION	CARDIOVASCULAR	SKIN
☐ Activity change	☐ Chest pain	☐ Acne
☐ Appetite change	☐ Leg swelling	☐ Color change
☐ Chills	☐ Palpitations	☐ Rash
☐ Diaphoresis	**Gastrointestinal**	☐ Wound
☐ Fatigue	☐ Abdominal distention	**ALLERGY/IMMUNO**
☐ Fever	☐ Abdominal pain	☐ Environmental allergies
☐ Unexpected weight change	☐ Anal bleeding/Hemorrhoids	☐ Food allergies
HEAD, EAR, NOSE & THROAT	☐ Blood in stool	☐ Immunocompromised
☐ Congestion	☐ Constipation	**NEUROLOGICAL**
☐ Dental problem	☐ Diarrhea	☐ Dizziness
☐ Drooling	☐ Nausea	☐ Facial asymmetry
☐ Ear discharge	☐ Rectal pain	☐ Headaches
☐ Ear pain	☐ Vomiting	☐ Light-headedness
☐ Facial swelling	**ENDOCRINE**	☐ Numbness
☐ Hearing loss	☐ Cold intolerance	☐ Seizures
☐ Mouth sores	☐ Heat intolerance	☐ Speech difficulty
☐ Nosebleeds	☐ Polydipsia	☐ Syncope
☐ Postnasal drip	☐ Polyphagia	☐ Tremors
☐ Rhinorrhea	☐ Polyuria	☐ Weakness
☐ Sinus pressure	**GENITOURINARY**	**HEMATOLOGIC**
☐ Sneezing	☐ Difficulty urinating	☐ Anemia
☐ Sore throat	☐ Dysuria	☐ Bruises/Bleeds Easily
☐ Tinnitus	☐ Enuresis	☐ Swollen Glands
☐ Trouble breathing	☐ Erectile Dysfunction	**PSYCHIATRIC**
☐ Trouble swallowing	☐ Flank Pain	☐ Agitation
☐ Voice change	☐ Genital Sore	☐ Behavior problem
EYES	☐ Hematuria	☐ Confusion
☐ Eye discharge	☐ Penile discharge	☐ Decreased concentration
☐ Eye itching	☐ Penile pain	☐ Dysphoric mood
☐ Eye pain	☐ Penile swelling	☐ Hallucinations
☐ Eye redness	☐ Scrotal swelling	☐ Hyperactive
☐ Glasses/Contact	☐ Testicular pain	☐ Nervous/anxious
☐ Photophobia	☐ Urgency	☐ Self-injury
☐ Visual disturbance	☐ Urine decreased	☐ Sleep disturbance
RESPIRATORY	☐ Urinary frequency	☐ Suicidal ideas
☐ Apnea	**MUSCULAR**	**GYNECOLOGICAL**
☐ Chest tightness	☐ Back pain	☐ Breast Lump(s)
☐ Choking	☐ Gait problems	☐ Breast-nipple discharge
☐ Cough	☐ Joint swelling	☐ Breast pain
☐ Shortness of breath	☐ Muscle Pain	☐ Menstrual irregularities
☐ Stridor	☐ Myalgias	☐ Painful intercourse
☐ Wheezing	☐ Neck pain/stiffness	☐ Vaginal Discharge

Patient's Name:_____ **Student ID:** _____