CSUDH

CALIFORNIA STATE UNIVERSITY, DOMINGUEZ HILLS

Student Health Center
(310) 243-3629

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

The undersigned (parent/guardian) of _____ who is _____years of age, hereby gives consent to the clinical staff of the Student Health Center at California State University, Dominguez Hills, for medical examinations, medical or surgical treatment of illness and/or injuries, diagnostic procedures (including x-ray and laboratory tests), administration of drugs, or for any other care when any or all of the foregoing is deemed necessary by, and is to be rendered under the general supervision of, a qualified California licensed health care provider. Treatment will be confidential and records will not be released to anyone without the permission of the undersigned, except by subpoena or other legally required reporting. While this authorization is given in advance of any specific diagnosis or any medical care being rendered, I understand that a reasonable effort will be made to notify me in the event that serious medical treatment is required. For a student-athlete, I further grant permission to transmit to the CSUDH Athletic Department any health care information which may affect my minor's participation in team sports.

I also understand that the Student Health Center is limited in its ability to provide continuous and/or comprehensive health care as the Student Health Center is closed in the evenings, on weekends, during holidays, and the provision of care is based on enrollment status.

Parent/Guardian
Name_____
(Please Print) Last First M.I.

Telephone Number ( )_____ ( )_____ ( ) _____
Home Cell Work

Mailing Address _____
(Number and Street (City and State) (Zip)

Parent/Guardian Signature_____ **Date**_____
(Required)

Name of Minor_____
(Print) Last First Middle

Student I.D. # _____ Date of Birth:_____/_____/_____/