CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO STUDENT HEALTH CENTER

CONSENT FOR MEDICAL TREATMENT OF A MINOR (UNDER 18 YEARS)

STUDENT'S NAME	ENT'S NAME DATE OF BIRTH	
AGE STUDENT	Γ ID#	SEX: M F
Telephone (Day) ()	(Ev	ening)
ADDRESS		
Street		
City	State	Zip
EMERGENCY: In a medical e	emergency whom should we c	contact?
Name	Phone_	
Relationship		
Health Insurance: None	Name of Carrier	
*****I hereby authorize the Stu San Bernardino to provide my any necessary medical or emerg	child (name of student)	
Signature of Parent/ Guardian		Date
A: Minors consent form rev/10/00		