CALIFORINA STATE UNIVERSITY, SAN BERNARDINO
STUDENT HEALTH CENTER
5500 UNIVERSITY PARKWAY
SAN BERNARDINO, CA 92407
(909) 537-5241 FAX (909) 537-7027

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

The undersigned parent/guardian of _____, a minor, Student I.D. Number_____, authorizes the Student Health Center at California State University, San Bernardino to consent to any medical or surgical treatment that is deemed advisable, and is to be provided by any licensed clinician under the provisions of the Medical Practice Act. The diagnosis or treatment may be provided at the office of the clinician.

This authorization is given in advance of any specific diagnosis, treatment, or care being required. It is given to provide authority to the above-named agent to give consent for diagnostic tests treatment, or care that a clinician may deem advisable.

☐ **Consent given for any injury or illness until this minor is 18 years of age.**

_____
Signature of parent/guardian

	( )	**( )**
Mother/Guardian	**Area Home Phone**	**Area Business Phone**
Or		
	( )	**( )**
Father/Guardian	**Area Home Phone**	**Area Business Phone**

Student's Birth Date_____ Date of last Tetanus Booster_____

Allergies to Medication_____

Name of Private Physician_____Phone ( )_____

Insurance Carrier_____ Policy #_____

==========

FOR STUDENT HEALTH SERVICES USE ONLY

Telephone consent to treat above-named minor given by:

_____
Name and Relationship to Patient

To_____ _____ Date_____
Student Health Center Staff Student Health Center Witness

Rev.9.28.16/kh