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 MINORS *(UNDER 18 YEARS OF AGE)*

The undersigned parent or guardian of _____
Student Name (First, Middle, Last)
who is _____ years old, hereby authorizes the medical staff of the CSUSB Student Health Center, as agents for the undersigned, to consent to any diagnostic procedure (including X-rays), to the administration of any medical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by, and is to be rendered under the general supervision of, any physician and surgeon licensed under the provisions of the Medical Practices Act. This authorization is given in advance of any specific diagnosis, treatment or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

This consent remains in effect until this minor is 18 years of age.

Parent or Guardian Signature: _____ **Date:** _____

Parent or Guardian Full Name: _____

Address: _____

Home Phone Number: ( ) _____ **Cell Phone Number: ( ) _____**

Business Phone Number: ( ) _____

Student's Date of Birth: _____ **Coyote/Student ID Number:** _____

Medications: _____

Allergies to Medication or Foods: _____

Date of Last Tetanus Booster: _____

Name of Private Physician: _____ **Phone: ( ) _____**

Insurance Carrier: _____ **Policy #:** _____

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FOR STUDENT HEALTH CENTER USE ONLY

Telephone consent to treat above-named minor given by:

_____
Name and Relationship to Patient

_____ Date: _____
Student Health Center Staff/Witness

Rev.3.9.18/kh