AUTHORIZATION FOR COLLEGE STUDENT HEALTH CENTER TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I am the ◯ parent

◯ guardian

◯ other person having legal custody _____

(describe legal relationship)

of _____, a minor.

(name of minor) First name/Last Name

Date of birth: _____ Student I.D. No.: _____

month/day/year

I/We hereby authorize Saddleback College and Health Center to act as my/our agent to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is recommended by, and to be rendered under the general or special supervision of, any licensed physician or surgeon, whether such diagnosis or treatment is rendered at the Health Center or at a hospital.

I/We understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above-named agent to give consent to any and all such diagnosis, treatment, or hospital care which a licensed physician recommends.

This authorization is given pursuant to the provisions of Family Code section 6910.

I/We authorize any hospital providing treatment to the above-named minor pursuant to the provisions of Family Code section 6910 to surrender physical custody of the minor to the above-named agent upon the completion of treatment. This authorization is given pursuant to Health and Safety Code section 1283.

These authorizations shall remain effective until *(month and day)* _____, 20___, unless sooner revoked in writing delivered to the agent named above.

Date: _____ Time: _____

Signature: _____

(circle relationship: parent/legal guardian/person having legal custody)

Signature: _____

(circle relationship: parent/legal guardian/person having legal custody)

(please complete all pages and attach parent/legal guardian photo ID)

MEDICALLY RELEVANT INFORMATION

Minor's name: _____
First Name/Last Name

Minor's birthdate: _____

Allergies to drugs, food, insect stings or bites: _____
_____

Medical conditions for which minor is currently being treated: _____
_____

Current medications and dosage: _____
_____

Restrictions on activities: _____
_____

Special dietary needs: _____
_____

Primary care physician: Name: _____
Address: _____
Telephone number: _____

Insurance Company: _____
ID number: _____
Group number: _____

Mother's name: _____
Mother's telephone number: _____
Mother's Email:_____

Father's name: _____
Father's telephone number: _____
Father's Email:_____

Guardian's name: _____
Guardian's telephone number: _____
Guardian's Email:_____
Guardian's Local Address: _____
Street Address Apt City State Zip Code