



Student Health & Counseling Center
California State University Channel Islands
One University Drive
Camarillo, CA 93012
Phone: (805) 437-8828 Fax: (805) 437-8829

Consent for Medical Treatment of Minors (under 18 years of age)

The undersigned parent or guardian of \_\_\_\_\_ who is \_\_\_\_ years old, hereby authorizes the medical staff of the CSUCI Student Health & Counseling Center, as agents for the undersigned, to consent to the administration of any medical treatments, immunizations, diagnostic procedures (including x-rays), or to any hospital care when any or all of the foregoing is/are deemed advisable 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.

Date \_\_\_\_\_ Signature \_\_\_\_\_
(Parent or Guardian)

Student's Full Name \_\_\_\_\_
(Last) (First)

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Student's Birth Date \_\_\_\_\_ Student ID Number \_\_\_\_\_

Telephone where parent or guardian may be reached:

Mother/Guardian Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Work/Cell #: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_

Home #: \_\_\_\_\_ Work/Cell #: \_\_\_\_\_

Allergies to medication or foods: \_\_\_\_\_

Any regular medication or pertinent health history: \_\_\_\_\_

Student's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_