CONSENT FOR MEDICAL TREATMENT OF MINORS

The undersigned parent or guardian of ______________________________
who is ____ years old, hereby authorizes the medical staff of the Klotz 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.

Date: ____________________

Parent or Guardian Signature: ______________________________

Parent or Guardian Full Name: ______________________________

Address: ______________________________

Telephone Numbers Where Parent or Guardian May Be Reached:

Home: ______________

Cell: ______________

Business: ______________

Student's Birth Date: ________________

Student ID Number: ________________

Allergies to Medication or Foods:

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Any Special Medications or Pertinent Information:

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____

Student's Physician: ____

Physician's Phone: ________________________

Please fax to: 818-677-2304 or

Mail to: CSUN SHC, 18111 Nordhoff Street, Northridge, CA 91330-8270