CALIFORNIA STATE UNIVERSITY, FULLERTON

Student Health and Counseling Center
800 N. State College Blvd., Fullerton, CA 92831 / T 657-278-2800 / F 657-278-3069

# Authorization to Consent for Treatment of a Minor

I, the undersigned, am the parent/legal guardian of _____, who is a minor and an enrolled student of California State University Fullerton.

I herby authorize California State University Fullerton, Student Health & Counseling Services' attending medical personnel, as an agent (s) for the undersigned:

- To consent to any diagnostic procedure (including lab and x-rays)
- To the administration of any counseling, or medical/minor surgical treatment
- To the administration of medications and immunizations
- To refer to another health facility
- When any or all of the above is deemed advisable.

This authorization shall remain effective until the student's 18th birthday.

Parent/Legal Guardian Signature: _____

Patient's Name: _____

CWID#_____

DOB: _____

Cell Phone# _____

Parent's Name: _____

Home Phone#_____

Cell Phone#_____