California State University, Chico
Student Health Service
Chico, CA 95929-0777
Phone (530)898-5241
Fax (530)898-4057

CONSENT FOR TREATMENT OF A MINOR

I give authorization to the Student Health Service at California State University, Chico to provide, upon request of my minor son/daughter,

____
Name

____
Date of Birth

all ordinary examinations and medical treatment until he/she reaches 18 years of age.

I also give my permission for the Student Health Service personnel to authorize any necessary emergency care prior to the time I can be reached to give permission.

_______________ ________________________________
Date Signature of Parent/Guardian

SHS STAFF USE ONLY FOR TELEPHONE CONSENT

Parental/guardian authorization given ☐ **Yes** ☐ **No**

Date and time of consent: _______________ _______________
Date Time

Method of verification of identity **Complete all that apply**

Call to ☐ Home ☐ Work

Student’s name ______________________________________ Student’s DOB ____________

Parent/guardian name ____

Parent/guardian address ____

Home phone number ________________________ Work phone number ________________

______________________________________ __________________
Staff Signature Date