San Francisco State University

Student Health Service

1600 Holloway Avenue
San Francisco, CA 94132-4200
Student Health Service

Tel: 415 338-1251
Fax: 415 338-2278
Web: www.sfsu.edu/~shs

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINORS

The undersigned parent or guardian of _____ who is_____ years old, hereby authorizes the medical staff of the Student Health Service of San Francisco State University, as agents for the undersigned to provide any diagnostic procedure (including x-rays), to the administration of any medical or surgical 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 Practice 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)

Telephone # where parent/guardian may be reached:

Home: ( ) _____ Work: ( ) _____
Mother / Guardian

Home: ( ) _____ Work: ( ) _____
Father / Guardian

Student Name _____
(last) (first)

Address _____

Student's birthdate:_____ Student ID number _____

Allergies to Medications or Foods: _____

_____

Date of Last Tetanus Shot: _____

Any special medications or pertinent information: _____

_____

Name of Physician: _____Phone: _____

Insurance Carrier: _____Policy #: _____