Mount Saint Mary's University
LOS ANGELES

STUDENT HEALTH SERVICES

Minor Authorization Consent Form for Medical Treatment

Student Name: _____ Student ID #: _____

Gender: _____ Date of Birth: _____ Age: _____

Address: _____

Cell Phone: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____

Name of Physician: _____ Phone Number: _____

The undersigned (parent/guardian) of _____, hereby authorizes the medical staff of Mount Saint Mary's University and/or Student Health Services, as agents for the undersigned to consent to any diagnostic procedure (including x-rays) to the administration of any medical, surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable 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 the California Family Code Section 6910 and Section 1283 of the Health and Safety Code of California.

Parent/Guardian Name (please print): _____ Signature: _____

Date: _____ Phone Number: _____ Work Phone Number: _____