

California State University, Sacramento
Student Health Center
6000 J Street, Sacramento, CA 95819-6045

Phone: (916) 278-6461
FAX: (916) 278-7359

DEAR PARENT/GUARDIAN:
*Be sure to complete the top portion of
this form in its entirety. Please PRINT clearly or type.
Your signature must be in ink. Thank you.*

CONSENT for TREATMENT of my MINOR SON/DAUGHTER

I hereby authorize the Student Health Center of California State University, Sacramento, to provide, at the request of my minor son/daughter _____ all ordinary examinations and medical treatments. I further give my permission for the Director of the Student Health Center at California State University, Sacramento, or her/his designee, to authorize any necessary emergency care in the event I cannot be reached to give direct permission.

Student's Name: _____

Date of Birth: _____ SS#: _____

Signature of Parent/Guardian Daytime Phone Number Date

Section Below for Student Health Center Staff Use Only

TELEPHONE CONSENT

Parent/Guardian's Name: _____

Address: _____

Parent/Guardian authorization given: Yes No

Date & time consent given: _____

Method of verification of identity: *check all that apply*

- Call at workplace
- Gave student's SSN
- _____
- Parent/Guardian's CDL: _____
- Gave student's DOB as _____

Caller's Signature & Title Date/Time Witness Signature