STUDENT
HEALTH SERVICES
CSU BAKERSFIELD

MINOR CONSENT FOR MEDICAL SERVICES

(For students 17 years of age and younger; not required for minors seeking reproductive services)

I hereby authorize California State University, Bakersfield Student Health Services to provide, at the request of my minor child, _____, medical services as needed. I further authorize any necessary emergency care in the event that I cannot be reached to give direct permission.

_____ _____

Parent/Guardian Signature Date

Minor's Name:_____

Date of Birth:_____ Student ID #:_____

Parent/Guardian Name:_____

Address/State/Zip:_____

Phone Number:_____

Emergency Contact: _____

Phone Number:_____ Relationship:_____

List of Medical Conditions: _____

Allergies:_____

FOR OFFICE USE ONLY

Telephone Consent

Parent/Guardian consent given: □ Yes □ No Date/Time Consent Given:_____

Method of Verification of Identity: (check all that apply)

□ Call at Workplace □ Parent/Guardian CA DL:_____ □ Gave Student's DOB as: _____

Non-Parental Consent for Minor:

□ This minor qualifies to consent for Reproductive Services

□ Form expires on (2 weeks from date): _____

_____

Staff Signature/Title Date

Student Health Services
California State University, Bakersfield
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661.654.2394 661.654.3301 Fax *csub.edu/healthcenter*