



MINOR CONSENT FOR MEDICAL SERVICES

(For students 17 years of age and younger; not required for minors, male or female, 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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