HEALTH AND WELLNESS CENTER

Minor's Special Attendance Authorization
Consent for Medical Treatment and/or Counseling

Term: ❑Spring ❑Summer ❑Fall 20_____
(Check Only One) (Year)

_____ _____ _____
Student's Name Student I.D. # Date of Birth

_____ _____
Name of Physician Physician's Phone

_____
Medical Insurance (including Medi-Cal)

Emergency Contact Information

Primary

Name: _____ Relationship to Student: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

In the event your primary contact cannot be reached, please provide an alternative contact.

Alternate

Name: _____ Relationship to Student: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Home Address: _____

City: _____ State: _____ Zip: _____

I, the parent/guardian of _____, hereby authorize the medical and counseling staff of Crafton Hills College Health and Wellness Center to consent to any diagnostic procedure (including x-rays), to the administration of any counseling, medical, surgical treatment, or to any accredited hospital 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 Section 25.9 of the California Civil Code. ***It shall remain in effect throughout the term designated on this form.***

_____ _____
Signature of Parent/Guardian **Date**