AUTHORIZATION FOR TREATMENT OF A MINOR AT ORANGE COAST COLLEGE STUDENT HEALTH CENTER

Student Name: ______________________________ DOB: _______________ OCC Student ID: ___________________

I __________________________________ parent or legal guardian of ____

Parent/Guardian Name   Student's Name (Print)

who is _____ years old, hereby authorizes the medical staff of Orange Coast College Student Health Center, as agents for the undersigned to consent to any diagnostic procedure, the provision of medical treatment and health services, including referral to community emergency and treatment services as deemed advisable by the Orange Coast College Student Health Center medical staff in accordance with accepted standards of nursing and medical practice. I impose no specific limitations or prohibitions regarding treatment. This authorization is given in advance of any specific diagnosis, treatment, or medical care being required, and pursuant to the provisions of Section 25.8 of the California Civil Code.

I understand that this authorization is valid for one year or until the minor noted above is 18 years of age.

(**Please attach a copy of a photo ID of the parent/legal guardian with matching signature.**)

Parent/Legal Guardian Signature: ____Date:___________________

Parent/Legal Guardian's Name (Print): ____

Address: ____ Phone: _________________________

Alternate Emergency Contact Name: ____Phone: _________________________

Minor's Medically Relevant Information

Allergies to medications, food, insect stings/bites, other: ____

____

Medical conditions for which the minor is receiving treatment: ____

____

Current medications and dosages: ____

Other pertinent medical information: ____

Primary Care Physician Name: ____

Address: ____

Phone: ____

Health Insurance Company & Plan Name: __________________________________ Phone: _____________________

ID & Group Number: ____