

**CONSENT FOR MEDICAL TREATMENT OF MINORS
(Students 17 years and younger at the time of acceptance)**

The undersigned parent or guardian of _____
Printed First and Last Name DOB

who is ____ years old, hereby authorizes the medical staff of the University of the Pacific Cowell Wellness Center, as agents for the undersigned to consent to any diagnostic procedure (including x-rays), to the administration of medical or surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable by the medical staff and rendered under the general supervision of a physician 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 25.8 of the California Civil Code.

Date _____ Signature _____
(Parent or Guardian)

Student's Full Name _____ / _____ Form Filed in medical chart
(Last Name) (First Name)

Address _____

Parent or Guardian's Phone Number:

Father/Guardian

Home: () _____ Bus: () _____ Cell: () _____

Fax: () _____

Mother/Guardian

Home: () _____ Bus: () _____ Cell: () _____

Fax: () _____

Student's Birth Date: _____ ID#: _____

Allergies: _____

Medications or Other Pertinent Medical Information: _____

Student's Physician: _____ Phone No.: _____

Fax/Written Consent: Telephonic Consent: Date: _____

CWC Staff: _____

Please Print

Filed in medical chart