



**CALIFORNIA STATE UNIVERSITY, LONG BEACH**  
**STUDENT HEALTH SERVICES**

Accredited by the Accreditation Association for Ambulatory Health Care, Inc.  
1250 Bellflower Boulevard Long Beach, California 90840-0201  
(562) 985-4771 Fax: (562) 985-1644

**Authorization to Consent to Treatment of Minor**

I, the undersigned, am the parent/legal guardian of \_\_\_\_\_, who is a minor and an enrolled student of California State University (CSU), Long Beach.

I hereby authorize California State University, Long Beach, Student Health Services' attending medical personnel, as an agent(s) for the undersigned:

- to consent to any diagnostic procedure (including lab and x-rays),
- to the administration of any counseling, or medical/minor surgical treatment
- to the administration of medications and immunizations
- to refer to another health facility

when any or all of the above is deemed advisable.

This authorization shall remain effective until the student's 18<sup>th</sup> birthday OR for the specified time period: \_\_\_\_\_.  
(please specify date)

\_\_\_\_\_  
Parent/Legal Guardian's Name (please print)

\_\_\_\_\_  
Signature

Date of Signature: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_