CALIFORNIA STATE UNIVERSITY, LONG BEACH
STUDENT HEALTH SERVICES
1250 Bellflower Boulevard Long Beach, California 90840-0201 (562) 985-4771 Fax: (562) 985-1644
Accredited by the Accreditation Association for Ambulatory Health Care, Inc.

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
(name of student)
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 examination/diagnostic procedure (including lab and x-rays),
- to the administration of any medical treatment, counseling, and/or minor surgical procedures,
- to the administration of medications and immunizations,
- to receive mental health counseling and/or psychiatric services,
- 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 18th birthday.

Student ID # _____ Date of Birth: _____

_____ _____ _____
Parent/Legal Guardian's Name (please print) Signature Date

Address: _____

Home Phone: _____ Cellular Phone: _____

SHS- Clinical Use Only

Parental Verbal Consent: ☐Mother ☐Father ☐Legal Guardian Parent/Legal Guardian's Name_____

Identified Child Name: _____ DOB: _____ ID: _____

Consent must be obtained by two staff members when seeing a minor patient with NO Authorization to Consent to Treatment of Minor is on file.

STAFF - PLEASE INFORM PARENT/LEGAL GUARDIAN THAT THIS MUST BE FOLLOWED UP WITH WRITTEN CONSENT ASAP

Staff 1: _____ _____ _____ _____
Full Name Title Date Time

Staff 2: _____ _____ _____ _____
Full Name Title Date Time