

California State Polytechnic University, Pomona

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT

The undersigned parent/guardian of _____, a minor, BroncoNumber _____, authorizes a Student Health Services Nurse of California State Polytechnic University, Pomona, as agent for the undersigned, to consent to any medical or surgical treatment, x-ray, anesthesia or hospital care that is deemed advisable, and is to be provided by any physician and surgeon licensed under the provisions of the Medical Practice Act. The diagnosis or treatment may be provided at the office of the physician or at a hospital.

This authorization is given in advance of any specific diagnosis, treatment, or hospital care being required. It is given to provide authority of the above-named agent to give consent for diagnostic tests, treatment, or hospital care that a physician and surgeon may deem advisable.

The undersigned authorizes any medical facility that has provided treatment to the minor, to surrender physical custody of the minor to the agent upon the completion of treatment.

- Consent given for this injury or illness only
Consent given for any injury or illness until this minor is 18 years of age

Signature of parent/guardian

Student Health Services Nurse Date Student Health Services Nurse Date

Mother/Guardian () Area Home Phone () Area Business Phone

OR () ()
Father/Guardian Area Home Phone Area Business Phone

Student's Birthdate Date of last Tetanus Booster

Allergies to Medication

Name of Private Physician Phone ()

Insurance Carrier Policy #

FOR STUDENT HEALTH SERVICES USE ONLY

Telephone consent to treat above-named minor given by Name and Relationship to Patient

To Student Health Services Nurse Date