**PASADENA CITY COLLEGE**
**STUDENT HEALTH SERVICES**
1570 E. Colorado Blvd. D-105
Pasadena, California 91106
626-585-7244

# MINOR AUTHORIZATION CONSENT FORM FOR MEDICAL TREATMENT &/OR COUNSELING

**Please submit this form to Admissions in L113, via fax 626-585-7915 or email to: enrollme@pasadena.edu**

_____
Student Name (Please Print) Last 8 digits of Lancer ID card

_____
Address City Zip

_____
Phone

_____ _____
Person to notify in an emergency Relationship

Medical Insurance (include MediCal) _____

Name of Physician _____ Phone Number _____

Student's Date of Birth _____ Age _____ Male [ ] Female [ ]

The undersigned (parent/guardian) of _____, hereby
(Print Student Name)
authorizes the medical and counseling staff of Pasadena City College and/or Student Health Services, as agents for the undersigned to consent to any diagnostic procedure (including x-rays) to the administration of any counseling, medical, surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable and is to be rendered under the general supervision of any physician and surgeon 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 25.9 of the California Civil Code.

_____ _____
Parent/Guardian Name (Please Print) Signature

_____ _____ _____
Date Home Telephone Number Work Telephone Number