



Student Health Services
3000 Mission College Blvd. Santa Clara, Ca 95054
Room W1-303 Phone #: (408) 855-5140 Fax #: (408) 567-0510

Parental/Guardian Consent for Medical Treatment

Student's Name _____

Date of Birth _____

I, _____ (parent/guardian) of the student named above, do hereby authorize a representative of Mission College to provide any of the following services:

_____ Immunizations. I have read and understand the risks and benefits listed on the Vaccine Information Sheet (VIS).

_____ Diagnostic procedure/ medical treatment regarding _____
(list symptoms or general problem)

_____ Physical examination

_____ Personal Counseling

_____ Urgent treatment for _____
(list injury or problem)

I have had the risks and benefits of the interventions indicated above when deemed advisable to be rendered under 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 25.9 of the California Civil Code.

In case of an emergency, please provide first aid or send my child to an emergency facility. I realize that Mission College cannot assume responsibility for the payment of expenses incurred.

Parent/Guardian Signature

Date signed

Name (Print)

Phone Number

Address

Telephone Consent verbally given by: _____		
Relationship to Patient: _____	Date: _____	

Healthcare Provider name and title

Signature

Date

Witness name and title

Signature

Date