

**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 _____