CAL STATE EAST BAY

STUDENT HEALTH & COUNSELING SERVICES
25800 Carlos Bee Boulevard
Hayward, CA 94542
Phone: 510-885-3735

Authorization to Consent to Treatment of Minor
Students Under 18 Years of Age

I, _____ the parent/legal guardian of _____,
(name of student)
who is a minor and an enrolled student of California State University (CSU), East Bay.

I hereby authorize California State University, East Bay, 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 Name: _____ Date of Birth: _____ Student ID#: _____

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

Signature: _____ Date: _____

Address: _____

Home Phone: _____ Cellular Phone: _____

SHCS Clinical Use Only		
Parental Verbal Consent: ☐ Mother ☐ Father ☐ Legal Guardian		
Parent/Legal Guardian's Name:		
Student Name:	DOB:	Student 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 Name & Title:	Date & Time:	
Witness Name & Title:	Date & Time:	

Rev.09/05/2023