CAL STATE EAST BAY

STUDENT HEALTH & COUNSELING SERVICES

25800 Carlos Bee Blvd., SHCS 1000,
Hayward, CA 94542
Phone: 510-885-3735 / Fax: 510-885-3230
Email: shcs@csueastbay.edu

AUTHORIZATION FOR AGENT TO CONSENT TO MEDICAL TREATMENT OF A MINOR

I hereby authorize the medical and counseling staff of the CSU East Bay Student Health and Counselling Services, as agents for the undersigned to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care deemed advisable by a licensed physician and surgeon and provided by that physician or under that physician's supervision, regardless of where that treatment is provided to:

Student Full Name: ____

Address: ____

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D.O.B. ____________________ Net ID __________________________

This authorization is made under California Family Code §6910.

Signed _______________________________________ Date __________________

Print Name ____

Please specify relationship to minor

- ☐ Parent with legal custody
- ☐ Guardian with legal custody

Telephone # where parent(s)/guardian(s) may be reached:

Parent / Guardian
Cell: ( ) ______________ **Home:** ( ) ____________ **Work:** ( ) ______________

Parent / Guardian
Cell: ( ) ______________ **Home:** ( ) ____________ **Work:** ( ) ______________