Student Health Services
One University Drive
Orange, CA 92866
714-997-6851

MEDICAL CONSENT TO TREAT A MINOR

Student Name (Please Print): _____ Date: _____

ID#: _____ Date of Birth: _____ Age: _____

Parent Name (Please Print): _____ Date: _____

Phone Number: _____

I, the undersigned, certify that I am the parent/legal guardian of the above named student, a minor for whom I am legally responsible, and do hereby authorize Chapman University Student Health Services to provide upon request of my or dependent medical treatment as deemed necessary by a medical professional. These include without limitations: , diagnostic or therapeutic treatment of illnesses and/or injuries, examinations, procedures and laboratory tests. I understand that my or dependent may be referred to outside medical professionals/specialists for treatment and that those facilities may require separate medical consent(s) of their own.

I understand that once my dependent reaches the age of majority in the State of California, my consent for treatment will no longer be required.

_____ _____

Signature of Parent/Guardian Date

12/6/2108