De Anza College Student Health Services
21250 Stevens Creek Blvd. Cupertino, CA 95014
Phone: (408) 864-8732 Fax: (408) 864-8983

CONSENT FOR MEDICAL TREATMENT OF A MINOR

Print Name of Minor Patient	Birth Date	Student ID#
Print Name of Parent or Guardian	Relationship	Parent or Guardian Phone #

_____ **(Initials)** I hereby give consent and authorization for any emergency or non-emergency diagnostic procedures and treatment that may be performed on an outpatient basis and which may include but are not limited to laboratory procedures, x-ray examinations or medical treatment, done at De Anza College Student Health Services by or under the instruction of the patient's health care provider. **My California Driver's License or valid form of identification is attached.**

_____ **(Initials)** In my absence, I would like the health care provider to discuss the matter with the persons designated below or the person's name under the California Caregiver's Authorization Affidavit form. I authorize those persons, insofar as the law of California permits me to do so, to enter in to the decision, to convey to the provider my consent, and to consent to said treatment.

Additional Names:

Name: _____ Phone number: _____
Address: _____

Name: _____ Phone number: _____
Address: _____

This authorization will remain in effect until the 18th birthday of listed minor.

Signature of Parent or Guardian (circle)	Date and Time

Return this form via in person, fax, US Mail or Email (email is not secure):
Fax: 408-864-8983
Mail: De Anza College Student Health Services, 21250 Stevens Creek Blvd. Rm 166, Cupertino CA 95014
Email address: dahealthclerk@fhda.edu

****

PHONE AUTHORIZATION—FOR STAFF USE ONLY

I have obtained telephone consent for De Anza Student Health Services (SHS) to provide medical care for the minor patient after speaking with the patient's parent/guardian, as listed above.

Duration of this Consent:

- ☐ This authorization will remain in effect until the 18th birthday of listed minor
- ☐ For this visit only
- ☐ This authorization shall remain in effect until_____, 20_____, unless sooner revoked in writing and delivered to said agent(s).

Person obtaining authorization:

Print SHS Staff Name	SHS Staff Signature	Date and Time

De Anza College Student Health Services
21250 Stevens Creek Blvd. Cupertino, CA 95014
Phone: (408) 864-8732 Fax: (408) 864-8983

STUDENT INFORMATION – REQUIRED TO ATTEND

All sections must be completed, with the signed original turned into the **office of Student Health Services.**

GENERAL INFORMATION

Parent/Guardian 1 First Name:	Last Name:
Best Number to Reach You:	Email:
Parent/Guardian 2 First Name:	Last Name:
Best Number to Reach You:	Email:
Special Instructions to Reach Parent(s) (if any):	

EMERGENCY MEDICAL INFORMATION (*Living in CALIFORNIA)

In the event of an emergency, the parent(s) listed above will be notified first. Please list additional emergency contacts below in case the parent(s) are unable to be notified. All emergency contacts below are authorized to pick up Minor Student for non-emergency purposes:

Name of Emergency Contact 1:	Phone Number:
Name of Emergency Contact 2:	Phone Number:
Name of Authorized Pick up Person:	Phone Number:
Name of Authorized Pick up Person:	Phone Number:
*Physician's Name or Medical Group:	Phone Number:
*Medical Record Number (or other medical identification Number):	

* It is important that proof of personal medical insurance and emergency contact information for parents/guardians is provided and carried by the minor at all times. The college and emergency medical personnel will need this critical information.

FOOD ALLERGIES/MEDICAL CONDITIONS

ANY KNOWN FOOD ALLERGIES:	
OTHER MEDICAL CONDITIONS THAT CLINICAL STAFF SHOULD BE AWARE OF:	
DIETARY LIMITATIONS:	