PARENTAL/GUARDIAN CONSENT FOR MEDICAL TREATMENT

Sierra College Health Services (HCHS)

Student Name_____ Date of Birth _____

SSN _____Today's Date _____

Parent Information:

Name _____

Address _____
City State Zip Code

Home phone (___)_____ Work phone (___)_____Cell phone (___)_____

Emergency Contact:

Name _____ Relationship to Student _____

Address _____
City State Zip Code

Home phone (___)_____ Work phone (___)_____Cell phone (___)_____

Consent:

I, _____ (parent/guardian) do hereby authorize a representative of Sierra College to provide:

_____ Immunizations

_____ Medical treatment regarding _____
(list symptoms or general problem)

_____ Urgent treatment for _____
(list injury or problem)

_____ Tuberculosis surveillance

_____ All medical treatment within scope of services at SCHS

Parent/guardian signature _____ Date _____

Telephone Consent:

Date _____

Medical Provider _____ _____
Print name and title Signature

Witness _____ _____
Print name and title Signature