



## Consent for Medical Treatment of Youth Under 18 Years of Age

\_\_\_\_\_  
Student's Full Name

\_\_\_\_\_  
Student ID #

\_\_\_\_\_  
Student's Birthdate

The undersigned parent or legal guardian of \_\_\_\_\_, who is \_\_\_\_ years old, hereby authorizes the staff of Cal Poly SLO, as agents for the undersigned, to consent to the administration of any medical treatments, immunizations, diagnostic procedures, including x-rays, or to any hospital care when any or all of the foregoing is/are deemed advisable and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act. This authorization is given in advance of any specific diagnosis, treatment or medical care being required and pursuant to the provisions of Section 25.8 of the California Civil Code.

\_\_\_\_\_  
Parent/ Legal Guardian's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Mother/Guardian Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Father/Guardian Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Youth's Physician

\_\_\_\_\_  
Phone Number

List allergies to medications and/or foods:

List any regular medication or pertinent health history: