

**PASADENA CITY COLLEGE**

1570 E. Colorado Blvd.  
Pasadena, California 91106

**STUDENT HEALTH SERVICES**

**MINOR'S AUTHORIZATION CONSENT FORM FOR MEDICAL TREATMENT  
&/OR COUNSELING**

\_\_\_\_\_  
Name (Please Print) Last 8 digits of Lancer ID card

\_\_\_\_\_  
Address City Zip

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Person to notify in an emergency Relationship

\_\_\_\_\_  
Medical Insurance (include MediCal)

\_\_\_\_\_  
Name of Physician Phone Number

\_\_\_\_\_  
Birthdate Age Male [ ] Female [ ]

The undersigned (parent/guardian) of \_\_\_\_\_, hereby authorizes the medical and counseling staff of Pasadena City College and/or Health Center, as agents for the undersigned to consent to any diagnostic procedure, (including x-rays), to the administration of any counseling, medical, surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

This authorization is given in advance of any specific diagnosis, treatment or medical care being required and pursuant to the provisions of Section 25.9 of the California Civil Code.

\_\_\_\_\_  
Parent/Guardian Name (Please Print) Signature

\_\_\_\_\_  
Date Home Telephone Number Work Telephone Number