

**CAL STATE SAN MARCOS  
STUDENT HEALTH & COUNSELING SERVICES**

**Parental Consent for Medical Care for Underage CSUSM Students**

California Family Code 6900 et seq. states that unless a specific exception applies, a minor's guardian or parent must consent to medical care. The exceptions include pregnancy and contraception-related services, STI/STD/HIV testing and treatment, drug and alcohol abuse treatment, outpatient mental health services and sexual assault-related services.

***IN CALIFORNIA, MINORS ARE INDIVIDUALS UNDER 18 YEARS OF AGE.***

If your minor son or daughter will be enrolled as a student at CSUSM, you are to complete and return the medical treatment form below.

Student's Name (printed) \_\_\_\_\_

Student I.D. # \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please pick one option and sign Sex: M \_\_\_\_\_ F \_\_\_\_\_

**OPTION 1.** I hereby authorized CSUSM Student Health Services to provide to my minor son or daughter any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of CSUSM Student Health Services or any outside physicians or facilities as needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

\_\_\_\_\_  
Parent/Guardian Name (print)                      Signature of Parent/Guardian                      Date

**OPTION 2.** I may choose a person employed at CSUSM to serve as a "designated agent" to consent for treatment of my minor son or daughter. This person can then sign any consent forms that may be necessary for diagnosis or treatment of my child, whether at CSUSM Student Health Service or another medical facility. (This designated agent can be any adult into whose care the minor has been entrusted. You may identify the authorized adult by title and employer [for example, Director of Student Health Services, CSUSM] rather than by name.)

The undersigned parent/guardian of \_\_\_\_\_, a minor (less than age 18), authorizes \_\_\_\_\_, as agent for the undersigned, to consent to any diagnostic tests or treatment that is deemed advisable, and is to be provided by any medical practitioner of CSUSM Student Health Services or any outside physicians or facilities as needed. This authorization is given in advance of any specific diagnosis or treatment that may be required.

\_\_\_\_\_  
Parent/Guardian Name (print)                      Signature of Parent/Guardian                      Date

***FOR STUDENT HEALTH SERVICES USE ONLY***

Telephone consent to treat the above-named minor was given by \_\_\_\_\_

Relationship to student:       Parent                       Legal Guardian  
Date \_\_\_\_\_      Time \_\_\_\_\_ am/pm                      # Called \_\_\_\_\_

\_\_\_\_\_  
Director of Student Health Service, CSUSM      Witness signature                      Date