SANTIAGO CANYON COLLEGE
HEALTH AND WELLNESS CENTER

HEALTH SERVICES CONSENT FOR TREATMENT OF MINOR

I hereby consent to and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician at the SANTIAGO CANYON COLLEGE HEALTH AND WELLNESS CENTER for my son/daughter by the name of:

______________________________	______________________________
(Print Name)	**(Print Parent's or Legal Guardian's Name)**
______________________________	______________________________
(Student Perm. Number)	**(Address)**
______________________________	______________________________
(Social Security Number)	**(City, Zip)**
______________________________	______________________________
(Birth date)	**(Work/Home Phone)**

What medication (prescription or non-prescription) is the above named student currently taking?

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Describe any medical condition(s) which the college physician should be aware of before treatment.

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____________________	______________________________
Date	**Signature**
	______________________________
	Relationship
____________________	______________________________
Date	**Witness**

CONSENT-MINOR.doc