

**SANTIAGO CANYON COLLEGE | STUDENT HEALTH AND WELLNESS SERVICES**  
**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:

**STUDENT INFORMATION**

Student Name	
Student ID Number	Birth Date

**PARENT OR LEGAL GUARDIAN INFORMATION**

Print Parent's or Legal Guardian's Name		
Address		
City	State	Zip Code
Cell Phone	Home Phone	Work Phone

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


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


\_\_\_\_\_  
Signature of Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date