CALIFORNIA STATE UNIVERSITY MONTEREY BAY

MEDICAL TREATMENT CONSENT FORM

I hereby give my consent to participate in the _____ Program duly approved by the California State University, Monterey Bay. I further agree to relieve the Trustees of the California State University, the California State University Monterey Bay, the State of California, and their respective employees, staff members and agents of any and all liabilities that may result from my participation in this program. The undersigned parent/guardian of the student hereby authorizes staff members of the California State University Monterey Bay to act as agents for the undersigned parent/guardian and to consent to any hospital care when any or all of the foregoing is deemed advisable by any physician licensed under the Medical Practice Act or by any dentist licensed under the Dental Practice Act. This authorization is given pursuant to California Family Code Section 6910 in advance of any specific diagnosis, treatment, medical care or dental care being required.

Student's Signature: _____ Date: _____

Parents' Signature: _____ Date: _____
(Signature of Parent/Legal Guardian (if under 18 years old)

Home Telephone: _____ Work Telephone: _____

Name & number to call if unable to reach a parent/guardian: _____

_____

The following additional information is requested as it will be necessary in providing treatment:

1. Is the above named student taking any medication(s)? Yes ☐ No ☐

   If yes, which medication(s)? _____

2. Is the above named student allergic to any medication(s)? Yes ☐ No ☐

   If yes, which medication(s)? _____

3. Do you have medical insurance? Yes ☐ No ☐

   If yes, please list name of the policy holder _____ Group # _____

4. Do you have other health insurance? Yes ☐ No ☐

   If yes, please list name of the policy holder: _____ Group # _____

5. Name of the participant's doctor: _____ Phone # _____