



University of California, Merced
Student Health & Wellness Services

MINOR CONSENT FORM

AUTHORIZATION FOR THIRD PARTY TO CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I (We), the undersigned parent(s), person(s) having legal custody, or legal guardian(s) of

Name of minor

Student ID#

a minor, do hereby authorize the University of California, Merced, Student Health Center Physicians or Designated Associates, as agent for the undersigned to consent to any medical or surgical diagnosis or treatment, anesthetic, or X-ray examination which is deemed advisable by, and is to be rendered under the general or special supervision of, any Student Health Service clinician.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but given to provide authority to aforesaid agent to give specific consent to any and all such diagnosis or treatment which a Student Health Center clinician, meeting the requirements of this authorization, may, in the exercise of their best judgment, deem advisable.

This authorization is given pursuant to the provisions of Section 6910 of the Family Code of California.

I (We) hereby authorize Student Health Services to surrender physical custody of the minor to the above named agent following treatment given pursuant to the provisions of Section 6910 of the Family Code of California. This authorization is given pursuant to Section 1283 of the Health and Safety Code of California.

This authorization shall remain in effect until _____, 20____ unless sooner revoked in writing and delivered to Student Health Services.

_____ <i>Signature</i> (check one) ☐ Parent ☐ Legal Guardian	_____ <i>Printed Name</i> ☐ Person having Legal Custody	_____ <i>Date</i>
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_____ <i>Signature</i> (check one) ☐ Parent ☐ Legal Guardian	_____ <i>Printed Name</i> ☐ Person having Legal Custody	_____ <i>Date</i>
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Both parents must sign if they both have legal custody.

Phone: _____ Address: _____