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

_____ STUDENT ID#_____
(Name of Minor)

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 and treatment which a Student Health Center clinician, meeting the requirements of this authorization, may, in the exercise of his/her 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.

_____ Date: _____
Signature

(check one) ☐ Parent ☐ Legal Guardian ☐ Person having Legal Custody

_____ Phone: _____
Address

_____ Date: _____
Signature of Witness Relationship to Minor