Parental / Guardian Consent for Medical Treatment

I, _______________________________ (parent/guardian) of the student named above, do hereby authorize a representative of Mission College to provide any of the following services:

________ Immunizations. I have read and understand the risks and benefits listed on the Vaccine Information Sheet (VIS).

________ Diagnostic procedure / medical treatment regarding __________________________________________ (list symptoms or general problem)

________ Physical examination

________ Personal Counseling

________ Urgent treatment for ___________________________________________________________________. (list injury or problem)

I understand the risks and benefits of the interventions indicated above when deemed advisable to be rendered under general care of a physician licensed under the provisions of the Medical Practice Act. This authorization is given in advance of any specific diagnosis, treatment, or medical care being required and pursuant to the provisions of section 25.9 of the California Civil Code.

In case of an emergency, please provide first aid or send my child to an emergency facility. I realize that Mission College cannot assume responsibility for the payment of expenses incurred.

_________________________________________   ___________________________________
Parent / Guardian Signature               Date signed

_________________________________________   ___________________________________
Name (Print)                   Phone Number

Address

---For Office Use Only---

Telephone Consent verbally given by:

Name of Parent / Guardian

Relationship to Patient

Healthcare Provider name and title

Signature

Date

Witness name and title

Signature

Date

Rev. 1/4/2010 pyl