**Dominican University of California Student Health Center**

# For students under 18 when starting Dominican only

*AUTHORIZATION AND CONSENT FOR SCHOOL RELATED MEDICAL CARE OF A MINOR*

Please read and complete this form. The information you provide is for the use of the Student Health Center in connection with certain routine care provided to the minor student while he/she is a student at Dominican University of California. This information is confidential.

| Student Last Name | First Name | M.I. | Semester/year of enrollment | Date of Birth |
|---|---|---|---|---|
| | | | | |
| Local Address (Street) or Dorm Room | City | State | Zip Code | Phone Number |
| | | | | |

1. I (we), the undersigned, am (are) the parent(s)/person having legal custody/legal guardianship of _____, a minor (the student), who is enrolled at Dominican University.
2. I (we) understand that the student may seek routine health care while a student at Dominican University of California. Such care may include diagnosis and treatment by a nurse practitioner, physician or student health center staff of Dominican University of California.
3. I (we) consent to and authorize the providing of routine health care services to the student, subject to the terms set forth in this Authorization and Consent form.
4. I (we) consent to and authorize the student to be evaluated, examined, and treated by the Student Health Center Staff at Dominican University of California for the following chief complaint:
   _____
5. I (we) understand that the health care services provided to the student through the Student Health Center will be provided at Dominican University of California, 50 Acacia Ave., San Rafael, CA 94901.

Signature: _____ Date: _____

Indicate Relationship: _____

==========

FOR OFFICE USE ONLY:

Date Rec'd: _____

Med Hx _____ Yes _____ No

MMR 1 _____ Yes _____ No

MMR 2 _____ Yes _____ No

MMRT:: _____

Tdap _____ Yes _____ No

TB _____ Yes _____ No

Resident: _____Yes _____ No

Varicella: _____ Yes _____ No _____ Waived

Meningitis: _____ Yes _____ No _____ Waived

Varicella Titers: _____

Sig Hx ____ P _____ Incomplete – Hold Placed: _____ Notes ~ Date contacted:

_____

_____

_____

_____