Santa Barbara City College Health Services

Minor Consent Form for Medical and Personal Counseling Services

Minor's Name ____

K# ______________________________ email ____

Address/State/ZIP ____

Phone ___________________________ Date of Birth ___________________ Age _______________

Mother/Guardian ____

Address/State/ZIP ____

Phone ____

Father/Guardian ____

Address/State/Zip ____

Phone ____

Emergency Contact ____

Phone ___________________________________ Relationship _______________________________

Alternate Contact ____

Phone ___________________________________ Relationship _______________________________

List any medical conditions ____

Allergies ____

I, the parent or guardian of the above minor, authorize and consent for my son or daughter to receive medical and/or personal counseling services as needed.

Signature ____ Date ___________________