



**Authorization for Treatment of a Minor**  
**REQUIRED FOR THOSE STUDENTS UNDER THE AGE OF 18**

**Student Health Center**

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Name: \_\_\_\_\_

Student ID: \_\_\_\_\_

Student Cell #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Authorization for Treatment of a Minor:**  
(Required for those students under the age of 18)

I (we) the undersigned parent/guardian of \_\_\_\_\_  
Do authorize medical care at agencies deemed necessary for the best interest of this student as determined by the staff of the University of Redlands. Such care may include, but is not limited to: x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is to be rendered under the auspices of a physician or nurse practitioner. It is understood this authorization (in accordance with Section 25.8 of the Civil Code of California) is given in advance of any specific diagnosis, treatment or hospital care required and is given to provide authority of power on the part of our aforesaid agent(s) to give specific consent to and for all such diagnosis, treatment, and /or hospital care which a physician or nurse practitioner, meeting all the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable. Furthermore, I (we) authorize any hospital which has provided treatment to the above-mentioned minor to surrender physical custody of such minor to the above-mentioned agent(s) upon the completion of treatment (pursuant to Section 1283 of the Health and Safety Code of California).

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Date