STUDENT HEALTH CENTERS

Consent for Procedures Diagnosis & Treatment

Date: _____/_____/_____ Student ID #:_____

Student's Name: _____

I have read, understand, and agree with the information statement(s) for the checked treatment(s), diagnosis(es) procedure(s) and I give permission for my daughter/son/or legal ward under 18 years of age.

_____ to be seen for the following treatment(s), diagnosis(es), procedure(s) and for the Palomar College Student Health Centers professional staff to administer them:

☐ Hearing and/or Vision Screening

☐ TB Skin Testing and TB Test Interpretation

☐ Hepatitis B Vaccine (an injection or shot)

☐ Tetanus and Diphtheria, Tdap (Tetanus Diphtheria Accelular Pertussis)

☐ Flu Vaccine (an injection or shot)

☐ Cholesterol Test (a blood test)

☐ Other _____

Executed in San Diego County, State of California on the date indicated below. This authorization shall remain in effect so long as the student is a minor and/or legal ward, or until rescinded in writing by the undersigned, whichever occurs first.

_____ _____/_____/_____
Print Parent/Guardian Name Date

_____ _____/_____/_____
Parent/Guardian Signature Date