Solano Community College
Student Health Center
Consent for Medical Treatment of Minor Form

Minor Student ______________________________________ DOB ____________ M/F SCC ID # ________________

Address/State/ZIP ___________________________________ Home Phone _________ Cell Phone ________________

Mother/Step Mother/Grandparent/Guardian ____

Home Phone ________________ Cell Phone _________________ Address/State/ZIP _____________________________

Father/Step Father/Grandparent/Guardian ____

Home Phone ________________ Cell Phone _________________ Address/State/Zip _____________________________

Doctor's Name ____ Phone ________________________

Medical Insurance _______________________________ Group/# ____

List any medical conditions ____

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Allergies ____ Epipen _______________

Bee Stings _______ Describe reaction ____Epipen _______________

Asthma _______________________________________ Inhalers ____

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

Signature ____ Date _______________________

Revised 12/15