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

4000 Suisun Valley Rd. Room 1407 Fairfield CA 94534 (707) 864-7163 Fax(707) 863-7813

Minor's Name _____

SCC ID or SS # _____

Address/State/ZIP _____

Phone _____ Date of Birth _____

Mother/Guardian _____

Address/State/ZIP _____

Phone _____

Father/Guardian _____

Address/State/Zip _____

Phone _____

Doctor's Name _____
Phone _____

Medical Insurance _____
Group/# _____

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 treatment as needed.

Signature _____ Date _____

C: minor consent