# 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 ______________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

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 ______________

**PLEASE RETURN FORM TO THE SCC STUDENT HEALTH CENTER**

Revised 11/17