BIOLA
UNIVERSITY

Student Health Center
13800 Biola Avenue
La Mirada CA 90639
PHONE 562.903.4841 FAX 562.906.4512

# MEDICAL CONSENT FOR MINOR CHILD

As legal parent or guardian of ______________________________________________________
(Please print minor's name)

I hereby give my consent for him/her to receive treatment for illness or injury, medication or immunization deemed advisable through Biola University Health Services. I also give consent to Biola University Student Health Services to make the necessary referrals to other facilities, if indicated.

Student's Date of Birth _____/______/______ Biola ID __________________________________

This consent shall remain in effect from the date of signature below through my child's 18th birthday. I may revoke this consent at any time by providing written notice to the Student Health Center.

Parent/Guardian Name ___________________________________________________________
(Please Print)

Parent/Guardian Signature _________________________________________________________

Date signed _____/______/_____

___________________________ ___________________________ ___________________________
Daytime Phone Home Phone Cell Phone