USC Engemann
Student Health Center

Place Patient Label Here

Treatment of A Minor
3rd Party Consent

California Family Code §6910 expressly provides that a parent or legal guardian may authorize an adult or entity into whose custody a child is entrusted to consent to necessary medical treatment. In the best interest of your child, the Engemann Student Health Center seeks such written authorization.

Pursuant to Family Code §6910, I am the:

❑ Parent ❑ Legal Custodian ❑ Guardian _____
(Describe Legal Relationship)

of _____ , a minor.
(First Name, Last Name of Minor)

USC ID: _____
(10 Digit USC Student Identification)

I hereby authorize the Engemann Student Health Center (ESHC) to provide treatment and care including x-ray examination, anesthetic, medical or surgical diagnosis or treatment, hospital care, mental health treatment or counseling to be rendered under the general or special supervision of any physician or surgeon an/or psychiatrist licensed under the provisions of the Medical Practice Act whether such diagnosis or treatment is rendered at ESHC or designated hospital. The administration of immunizing vaccines is also authorized.

- It is understood that this authorization is given in advance of any specific diagnosis or treatment being required, but is given to provide authority and power to provide necessary diagnostics and care.
- This authorization shall remain in effect until minor turns 18, unless written revocation is delivered to ESHC.
- If there are any changes in the status of legal guardianship/parent status, I understand that it is my responsibility to notify ESHC of any such changes.
- If you choose not to sign or consent to this form, emergency medical providers will provide stabilization treatment, but nothing further, until you are contacted for consent.

Name: _____ Signature: _____ Date: _____
First, Last MM / DD / YY

Please Fax to the HIM Dept.: 213-740-4961 or hand deliver during initial visit

ESHC Staff Use Only for Telephone Consent

Authorization obtained via telephone consent: ❑ Yes ❑ No

Date and Time of Consent: _____ Time: _____ ❑ AM ❑ PM
MM / DD / YY

Method of verification of Identity: (Complete all that apply)

Call to: ❑ Home ❑ Work ❑ Mobile

Minor's Name: _____ Minor's Birth Date _____
MM / DD / YY

Parent/Guardian Name: _____

Parent/Guardian Address: _____

Parent/Guardian Phone: ❑ Home ❑ Work ❑ Mobile _____

Witness Signature: _____ Date: _____
MM / DD / YY

Witness Signature: _____ Date: _____
MM / DD / YY

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Source: California Hospital Assoc. Reference: Family Code Section 6922 05/30/09