SAN FRANCISCO STATE UNIVERSITY

ENTERPRISE RISK MANAGEMENT
1600 Holloway Avenue, ADM 260
San Francisco, CA 94132-4260
Tel: 415/338-2565
Fax: 415/338-0597
erm.sfsu.edu

AUTHORIZATION TO PROVIDE EMERGENCY MEDICAL, GENERAL HEALTH, AND/OR MENTAL HEALTH SERVICES & TREATMENT OR TO GIVE CONSENT TO OTHER PROFESSIONALS TO PROVIDE THESE SERVICES TO A MINOR STUDENT

I/We, the parents or legal guardians of _____,
(Print minor's first and last name)
(Date of birth: _____), authorize the State of California, the Trustees of California State University, San Francisco State University and its employees officers, directors, volunteers, agents, and representatives (collectively "UNIVERSITY") to provide the services we have indicated below to my/our son/daughter, who is a minor student attending (or participating in a program in residence at) San Francisco State University:

☑ Emergency medical services and treatment (though no parental consent is required in life-threatening situations);

☑ General medical services and treatment; and

☑ Mental health services and treatment.

I /We also understand that an attempt will be made to notify us prior to treatment if our son/daughter is in need of medical treatment or care, but UNIVERSITY may rely on this authorization in situations where notification is unsuccessful or where a written authorization is required.

I/We also authorize University to consent to such treatment or hospitalization by other medical services providers as may be deemed necessary under the circumstances, including, but not limited to, hospitalization, x-ray examinations, anesthesia and surgery. I/we authorize UNIVERSITY to provide the medical professionals treating my son/daughter with the medical history that UNIVERSITY may have on my son/daughter, if requested by the medical professionals.

We intend for this authorization to take effect and treatment may begin as of the date we sign the authorization, and the authorization will remain in effect until the minor student reaches the age of 18.

I/We understand that UNIVERSITY is not responsible for providing any insurance for my/our son/daughter in connection with treatment or care, and that any medical or hospitalization expenses not covered by my/our insurance is my/our responsibility.

I/We RELEASE, HOLD HARMLESS, AND COVENANT NOT TO SUE, the State of California, the Trustees of California State University, San Francisco State University and the employees officers, directors, volunteers, agents, representatives of each of them or the members of Emergency Medical Services, Student Health Center, Counseling Center and all other representatives of any of them from and for any and all claims, causes of action, damages and liabilities from any cause, whether or not foreseeable or contributed to by the negligent acts or omissions of UNIVERSITY or others.

ENTERPRISE RISK MANAGEMENT
1600 Holloway Avenue, ADM 260
San Francisco, CA 94132-4260
Tel: 415/338-2565
Fax: 415/338-0597
erm.sfsu.edu

Signature of Parents or Guardians: _____

Printed Name of Parents or Legal Guardians: _____

Date: _____

Relationship to Student: _____

Address: _____

Phone: _____ E-mail: _____

Health Insurance Carrier: _____

Policy Number: _____

OPTIONAL MEDICAL HISTORY

Known Allergies (including medicinal allergies): _____
_____
_____

Medical needs or conditions: _____
_____
_____

Current medications AND dosages: _____
_____
_____

PHYSICIAN'S CONTACT INFORMATION

Name: _____
Address: _____
Phone: _____ Fax: _____
E-mail: _____