

**Butte Community College Student Health Clinic**  
3536 Butte Campus Drive Oroville, CA 95965  
(530) 895-2441

**AUTHORIZATION TO TREAT A MINOR**

I (We), the undersigned parent(s), or legal guardian of:

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_ ID#: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Hereby authorize Butte College Student Health Clinic to provide, at the request of my minor son/daughter, access to medical assessment, diagnosis and treatment, including over-the-counter medication.

Previous surgery or minor injury: \_\_\_\_\_  
\_\_\_\_\_

List any allergies the child is known to have: \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_

Medication child is taking: \_\_\_\_\_  
\_\_\_\_\_

Medical Insurance and Policy Number: \_\_\_\_\_  
\_\_\_\_\_

I (We) further give permission for the Student Health Clinic Practitioner, or his/her designee, to authorize any necessary emergency care, and I (We) understand that care will not be withheld if I (We) cannot be reached.

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Print Name	Parent/Guardian Signature	Relationship to minor
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Daytime Phone Number	Date
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**NOTE:** It is California State law that parental/guardian consent is not required for pregnancy testing, counseling, and contraception for minors of all ages (Family Code s6925), nor minors twelve years of age or older receiving care for sexually transmitted infections and HIV testing (Health and Safety Code s199.27).