



Santa Barbara City College Health Services

Minor Consent Form for Medical and Personal Counseling Services

Minor's Name _____

Social Security # _____

Address/State/ZIP _____

Phone _____ Date of Birth _____ Age _____

Mother/Guardian _____

Address/State/ZIP _____

Phone _____

Father/Guardian _____

Address/State/Zip _____

Phone _____

Emergency Contact _____

Phone _____ Relationship _____

Alternate Contact _____

Phone _____ Relationship _____

List any medical conditions _____

Allergies _____

I, the parent or guardian of the above minor, authorize and consent for my son or daughter to receive medical and/or personal counseling services as needed.

Signature _____ Date _____