Riverside Community College District
Health Services

PERMISSION TO TREAT A MINOR/EMERGENCY INFORMATION

I (parent/legal guardian) grant permission and authorize the administration of all diagnostic and therapeutic treatments that may be considered advisable or necessary in the judgment of the physician/nurse practitioner/registered nurse/counselor at Riverside Community College District's Health Services.

Student Printed Name **Student ID Number**

Printed Name of Parent/Legal Guardian **Signature of Parent/Legal Guardian** **Date**

Address **Street** **City** **Zip Code**

EMERGENCY INFORMATION:
In case of emergency please contact:

Name **Relationship**

Phone Home **Work** **Cell**

Allergies:

Serious Medical Conditions:

Medications:

All medical information and records are subject to guidelines of the Health Insurance Portability and Accountability Act (HIPPA).