SANTA MONICA COLLEGE
INTERNATIONAL EDUCATION
CENTER
1900 Pico Blvd
Santa Monica CA 90405

MINOR AUTHORIZATION CONSENT FORM FOR
F1 International Students
MEDICAL TREATMENT &/OR COUNSELING
Please upload this form in your SMC online application (iApp)

_____
Student Name (Please Print) SMC ID#

_____
Guardian's Address City Zip code

_____
Phone Email

Person to notify in an emergency _____ Relationship_____

Student's Date of Birth _____Age _____ Male ☐ Female ☐

The undersigned (parent/guardian) of _____, hereby
(Print Student Name)
authorizes the medical and counseling staff of Santa Monica College and/or Student Health Services, as agents for the undersigned to consent to any diagnostic procedure (including x-rays) to the administration of any counseling, medical, surgical treatment, or to any hospital care when any or all of the foregoing is deemed advisable and is to be rendered under the general supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act.

This authorization is given in advance of any specific diagnosis, treatment or medical care being required and pursuant to the provisions of Section 25.9 of the California Civil Code.

_____ _____
Parent/Guardian Name (Please Print) Signature

_____ _____ _____
Date Home Telephone Number Work Telephone Number