Youth Protection Program

Medical Treatment Consent Form

_____ _____ _____

Minor/Youth Participant Last Name **First Name** **MI**

I hereby give my consent for the minor/youth to participate in the_____ Program duly approved by the California State University, Monterey Bay. I further agree to relieve the Trustees of the California State University, the California State University Monterey Bay, the State of California, and their respective employees, staff members and agents of any, and all liabilities that may result from my participation in this program. If signing on behalf of a youth/minor participant, the undersigned parent/guardian of the student hereby authorizes staff members of the California State University Monterey Bay to act as agents for the undersigned parent/guardian and to consent to any hospital care when any or all of the foregoing is deemed advisable by any physician licensed under the Medical Practice Act or by any dentist licensed under the Dental Practice Act. This authorization is given pursuant to California Family Code Section 6910 in advance of any specific diagnosis, treatment, medical care or dental care being required.

The following additional information is requested as it will be necessary in providing treatment:

1. Is the above-named student taking any medication(s)? ◯ **YES** ◯ **NO**

   If yes, which medication(s)?

   _____

2. Is the above-named student allergic to any medication(s)? ◯ **YES** ◯ **NO**

   If yes, which medication(s)?

   _____

◯ I hereby authorize consent for a licensed medical professional to provide the necessary and/or required medication(s)/prescription(s) the minor/youth participant.

◯ The minor/youth participant is able to administer their own medication(s)/prescription(s).

3. Does the above-named student have any known allergies i.e. bees, nuts, dairy?
   ◯ **YES** ◯ **NO**

   If yes, please advise as to what the allergen(s) is/are:

   _____

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4. Do you have medical insurance? ◯ **YES** ◯ **NO**

If yes, please list name of the policy holder: _____

_____ _____ (____)_____

Policy number Group number Phone number

5. Do you have other (secondary) health insurance? ◯ **YES** ◯ **NO**

If yes, please list name of the policy holder: _____

_____ _____ (____)_____

Policy number Group number Phone number

6. Name of the participant's doctor: _____

(____)_____

Doctors phone number

I have been informed and understand there remains a risk of exposure to COVID-19. I understand that regardless of any precautions taken, an inherent risk of exposure to COVID-19 will exist.

◯ I hereby authorize consent to treat the minor/youth participant.

◯ I hereby *do not* authorize consent to treat the minor/youth participant.

Parent/legal guardian Authorization:

Parent/legal guardian Printed Name: _____

Parent/legal guardian Signature: _____

(____)_____ (____)_____

Contact phone Alternate phone

*For CSUMB staff only: If the parent/legal guardian has given consent to treat the minor/youth participant, ensure that the "authorize consent" option is checked appropriately on the Participant Registration Form, and attach the Medical Treatment Consent form to it.