AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

I, the parent/legal guardian of ________________________________ (student’s name), in consideration of the services rendered by Leeward CC Student Health Center, hereby voluntarily and knowingly, authorize and give my express consent to Leeward CC Student Health Center, for the administration of TB tests, immunizations, medical treatment for illnesses or injuries, and emergency care to the above named student as deemed necessary by the Leeward CC Student Health Center staff.

SIGNATURE OF PARENT OR LEGAL GUARDIAN ________________________________ DATE ______________

Revised 9/6/2018