

Parental Authorization
Student Health Center



Parental Authorization for Treatment of a Minor

If your student will be under the age of 18 when they arrive on the APU campus, we will need your authorization for most medical treatment that may be required. Please sign the statement below and return this form to the Student Health Center.

My child, _____, DOB _____, will be a minor when arriving on campus and may need medical treatment at the APU SHC. I hereby consent for my child to receive care at the Azusa Pacific University Student Health Center.

Name of parent or legal guardian Signature of parent or legal guardian Date

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