To Whom It May Concern:

I, _____________________________, give my permission to the Azusa Pacific University Student Health Center to talk openly with my parent(s) about:

☐ All of my medical issues up to today, including mental health issues
☐ All of my medical issues (including future ones) unless I notify you otherwise
☐ Specific dates and/or issues to discuss or exclude: _____________________________

________________________________________

Mother’s Name: _____________________________

Home Phone: _____________________________  Cell Phone: _____________________________

Father’s Name: _____________________________

Home Phone: _____________________________  Cell Phone: _____________________________

________________________________________

Print Name & Date of Birth  Student ID #

Signature  Date

________________________________________

Student Health Center Staff  Date

Note: If student is unable to come to the Student Health Center in person and sign this form, this form must be notarized and faxed to the Student Health Center. This form will be in effect for one year, unless otherwise noted.

Notary