I _________________________ give permission for my child __________________________
(Parent or Legal Guardian’s Name) (Student’s Name)
to receive the services stated below at the Student Health Center of City College of San Francisco, pending their personal consent.

TB Testing: __________________________ Date: ________________
(Parent or Legal Guardian’s Name)

Immunizations:
I have received and reviewed the current Vaccine Information Statement(s) and give permission for the following immunizations: ____________________________
__________________________________________
(Parent or Legal Guardian’s Name) Date: ________________
__________________________________________
(Parent or Legal Guardian’s Name)

Other general medical services __________________________ Date: ________________
(Parent or Legal Guardian’s Name)

Comments:

*Services that have an associated fee will be discussed with the patient before being rendered.