UNIVERSITY OF CALIFORNIA, IRVINE

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO • SANFRANCISCO • SANTA BARBARA • SANTA CRUZ

International Programs
Tel: 1-949-824-5414
Fax: 1-949-824-8065
Email: ip@ce.uci.edu
510 E. Peltason Dr.
Irvine, California 92697-5700, U.S.A.

Authorization for Medical and/or Psychological Treatment of a Minor

I. PARENT/LEGAL GUARDIAN INFORMATION (Please type or print legibly)

a. Name of Minor _____
(Last, First, Middle)

b. Name of Parent/Legal Guardian _____
(Last, First, Middle)

Address _____
(Street or P.O. Box, City, State, Zip Code)

Telephone Number: Day (____) _____ Night (____) _____

II. ADULT RELATIVE OR FAMILY FRIEND IN UNITED STATES

Does the Minor have an adult relative or family friend in the United States? ☐Yes ☐ No

a. Name of Parent/Legal Guardian _____
(Last, First, Middle)

b. Address _____
(Street or P.O. Box, City, State, Zip Code)

c. Telephone Number: Day (____) _____ Night (____) _____

d. Email address: _____

e. Does the relative or family friend speak English? ☐Yes ☐ No

III. AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR PSYCHOLOGICAL TREATMENT

I, the undersigned parent or legal guardian of _____
(Name of minor)

do hereby authorize The University of California, Irvine Division of Continuing Education and its agents or representatives to consent, on my behalf, to any medical, psychological, and/or hospital care or treatment (including locations outside the U.S.) to be rendered to him or her upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization in the event services are not covered under the insurance policy.

_____ Date _____
(Signature of Parent or Legal Guardian)