AZUSA PACIFIC UNIVERSITY

PO Box 7000
Azusa, CA 91702
(626) 815-2100

Student Health Center

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