

Counseling Center and Student Health Services Consent for Treatment of a Minor

First Name of Minor (print)

Last Name of Minor (print)

Student ID Number

Date of Birth

Home Phone of Parent or Legal Guardian

Alternate Phone of Parent / Guardian

I, the undersigned, as the parent or legal guardian of _____, a minor, hereby authorize physical and mental health treatment of such a minor that may be considered either necessary or appropriate. I understand that information provided is confidential and will not be released without my consent, unless otherwise permitted by law.

Signature of Parent or Guardian

Date

Name of Parent or Guardian (print)

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Pertinent Medical History: _____

Date of Last Tetanus Booster: _____