

OFFICE USE ONLY



# Minor Medical Treatment Consent Form

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_

REQUIRED - UF ID Number (8 digits):

□ □ □ □ - □ □ □ □

## Parent/Guardian Medical Treatment Consent

### For Students Under 18 Only

I hereby authorize the University of Florida Student Health Care Center and SHCC Psychiatry at the UF Counseling and Wellness Center to employ diagnostic procedures and to render any treatment or medical, surgical, psychological or psychiatric care deemed necessary to the health and well-being of my child.

I grant permission for the transfer of my child to an accredited hospital or other health care facility if deemed necessary by the medical or mental health provider.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Student

-----OFFICE USE ONLY-----

### Telephone Consent Given By:

Parent/Guardian Name (Print): \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_

### Witnesses: (2 Signatures required)

SHCC EMPLOYEE: \_\_\_\_\_  
Print Name Signature

SHCC EMPLOYEE: \_\_\_\_\_  
Print Name Signature

### IMPORTANT! KEEP A COPY OF THIS PAGE FOR YOUR RECORDS.

Fax (no cover sheet) OR mail this completed form at least 3 weeks prior to UF Preview/orientation.

Fax: (352) 392-0938; Mailing Address: UF Student Health Care Center, Health Compliance, P.O. Box 117500, Gainesville, FL 32611-7500