OFFICE USE ONLY

Minor Medical Treatment Consent Form

Name: _____

Date of Birth: _____ **Phone:** _____

REQUIRED - UF ID Number (8 digits):

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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

Completed forms can be returned via:

Fax:
(352) 392-0938

Mail:
UF Student Health Care Center,
Health Compliance
P.O. Box 117500, Gainesville, FL
32611-7500

****Email:**
healthcompliance@shcc.ufl.edu

***Please note**: Email sent over the Internet is not necessarily secure. Please be aware that the University of Florida (UF) Health Compliance Office and the UF Student Health Care Center (SHCC) cannot guarantee the confidentiality or security of any information sent over the Internet when using email. UF and/or the SHCC shall not be liable for any breach of confidentiality resulting from such use of email via the Internet.*

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