University of Wisconsin Oshkosh
STUDENT HEALTH CENTER

Return completed form to:
Student Health Center
University of Wisconsin Oshkosh
800 Algoma Blvd., Radford Hall
Oshkosh, WI 54901-8694

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of_____ grant the following authorization for medical and treatment of this minor by a health care professional should the need arise while he/she is attending the University of Wisconsin Oshkosh.

I grant permission to the University of Wisconsin Oshkosh Student Health Center for evaluation and treatment of medical problems. I understand that should a major medical problem arise, an attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary for said minor by a licensed physician or nurse.

Date _____Parent/Guardian Signature _____

Medical Information (please print)

Student's name _____Social Security Number _____-_____ - _____

Age _____Birth date _____ Date of last Tetanus Toxoid: _____

History of Chronic illness: _____

History of surgeries or hospitalizations: _____

Medication allergies: _____

Present medication: _____

_____

_____

Other information that would be useful in the event medical treatment is necessary. _____

_____

_____

_____

Contact Information (please print)

In an emergency, parents or legal guardians can be reached as follows:

Name_____Relationship to minor_____

Address_____Daytime phone_____

City/State/Zip_____Evening phone_____