USF UNIVERSITY OF SOUTH FLORIDA

Student Health Services

PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I,_____ being the parent and/or legal Guardian of
Print Name

the minor age child, _____ _____
Print Name Date of Birth

hereby give consent for medically necessary treatment and care, including emergency treatment, by the health care providers affiliated with the University of South Florida Student Health Services, College of Medicine and the USF Physicians Group. In the event I am not available at a time this minor requires medical care, I give parties listed below the authority to seek and authorize care.

*Consent is only valid if signed and dated by **both** the Parent/Legal Guardian and a Witness that is over the age of 18.*

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name of Parent/Legal Guardian

_____ _____
Signature of Witness Date

_____ _____
Print Name of Witness Date of Birth

ALTERNATE PARTIES AUTHORIZED TO SEEK MEDICAL CARE FOR MINOR CHILD

1) _____ _____
Print Name Relationship

Work Phone: _____ Home Phone: _____ Initial of Legal Guardian: _____

2) _____ _____
Print Name Relationship

Work Phone: _____ Home Phone: _____ Initial of Legal Guardian: _____

This consent will remain in effect for one year from the date the consent was signed.

FOR OFFICE USE ONLY: U#: _____

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