UNIVERSITY OF
NOTRE DAME
UNIVERSITY HEALTH SERVICES

Saint Liam Hall
Notre Dame, Indiana
46556 USA

tel (574) 631-7497
fax (574) 631-6047
web http://uhs.nd.edu

AUTHORIZATION FOR CONSENT FOR TREATMENT OF A MINOR

Parent or legal guardian of: _____
Name of Minor (Last, First, Middle)

_____ _____
Date of Birth NDID# or SS#

I consent to University Health Services providing diagnostic and treatment services for my child. I understand that if any invasive or serious procedures are needed I will be contacted in advance of the procedure or service, unless it is an emergency. **Failure to have consent on file except in emergency situations may delay treatment, while we attempt to obtain your consent.**

This consent expires on the patient's 18th birthday unless revoked in writing.

_____ _____ _____
Print Name of Parent or Guardian Signature Date

_____
Relationship to Student/Patient

Phone Numbers: Home:_____ Work:_____

Return this Form by mail to:

University Health Services
Room 111
Notre Dame, IN 46556

Or Fax to: (574) 631-6047