OFFICE USE ONLY

UF UNIVERSITY of FLORIDA

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

----------**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