Student Health Center

PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I, _____, being the parent and/or legal Guardian of the minor age child, _____, hereby give consent for medically necessary treatment and care, including emergency treatment, by the health care providers affiliated with the Slippery Rock University, Student Health Center. In the event I am not available at the time this minor requires medical care or there is an emergency that does not allow time to contact me, I give the parties listed below the authority to seek and authorize care.

This consent will remain in effect until I sign a written revocation or my child turns 18 years of age.

Signature of Parent/Legal Guardian: _____ Date: _____

Witness: _____ Date: _____

ONE TIME VERBAL AUTHORIZATION

Verbal Authorization obtained: _____ _____
Print Name Relationship

Received by SHC Staff: _____ _____
Signature/title Date

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: _____

PATIENT NAME: _____ DOB: _____

Health Records | Student Health Services | 204 Campus Drive | Slippery Rock, PA 16057 Phone: 724-738-2052 | Fax: 724-738-2078