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