

**Indiana University Health Center
600 N. Jordan Avenue
Bloomington, Indiana
47405-3191**

Consent for Medical Treatment of a Minor

Date:

In order to enable the Indiana University Health Center to provide prompt care to your son or daughter who has not yet attained the age of 18, we urge you to read and complete this consent form. Please return it to the Indiana University Health Center, 600 N Jordan Ave., Bloomington, IN 47405, Fax: 812-855-4628. In this way, we can help your child without delay should an emergency occur.

I, _____, declare that I am the _____
(Full name of parent/guardian) (Father/Mother/Guardian)

of _____
(Full name of minor)

University ID # _____, a minor, age _____,

born _____, 20_____.

Please provide the following information concerning said minor:

Allergic Reactions: _____

Present Medication (if taking, now): _____

Date of Last Tetanus Booster: _____

Any past illness or other information that would be useful in the event medical treatment is necessary:

IN CASE OF EMERGENCY:

Telephone: (Home) _____ (Work) _____ (Cell) _____

Address: _____

Please complete ONE of the following:

I grant permission to the medical providers, nurses, assistants, or other persons responsible for his/her care to act on my behalf for said minor in granting permission for evaluation and treatment of medical or psychological problems and/or preventative care, including vaccines. In the event that I cannot be reached, I hereby give my consent to such medical services as deemed necessary, including minor surgery, lab tests, x-ray examinations, medications, and/or physical therapy to be rendered to said minor by a licensed/certified health care provider.

Date: _____ Signature: _____ (Parent or Guardian)

I do not wish medical care of any kind except emergency care to be provided.

Date: _____ Signature: _____ (Parent or Guardian)

I authorize limited medical care as follows: _____

Date: _____ Signature: _____ (Parent or Guardian)

Witnessed by (person 18 years of age or older) – must be signed by someone other than person giving consent:

Signature: _____ Printed Name: _____

Number and Street Address: _____

City, State and Zip Code: _____ Date: _____