

**Student:** \_\_\_\_\_

**UIS Student ID number:** \_\_\_\_\_

**Date of birth:** \_\_\_\_\_

To be completed by a Parent or Guardian if the student will be under the age of 18 upon matriculation at the University of Illinois at Springfield.

I, the parent/legal guardian of (print student name) \_\_\_\_\_ ,  
in consideration of the services rendered and of the facilities provided by the University of Illinois at Springfield Campus Health Service, hereby voluntarily and knowingly authorize and give my expressed consent to hospitalization, a visit or visits to the University of Illinois at Springfield Campus Health Service, a hospital, an emergency care facility, or a physician's office while in attendance at the University of Illinois at Springfield, for the purpose of clinical observations, and/or the administration of treatment, including, but not limited to, the taking of whatever x-rays, injections, or drugs that may be considered necessary or desirable in the observation, diagnoses, and the treatment of his/her case by the physician in attendance and/or the staff of the University of Illinois Campus Health Service at Springfield, Illinois.

\_\_\_\_\_  
Signature of parent/legal guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of parent/legal guardian

\_\_\_\_\_  
Address of parent/legal guardian

\_\_\_\_\_  
Emergency Phone number of parent or guardian