UNIVERSITY OF ILLINOIS SPRINGFIELD
Campus Health Service • BSB 20 • (217) 206-6676 • Fax (217) 206-7779

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

place label here

Name:

UIN:

Birth date:

Date:

To be completed by parent or guardian if student is less than 18 years of age when seeking healthcare services from Campus Health Service at the University of Illinois Springfield.

As the parent/legal guardian of (print student's name):_____

I hereby authorize and give my express consent to UIS Campus Health Service for the administration of medical treatment for illness or injury, physical or mental health counseling and routine health maintenance to the above-named student, as deemed necessary in the sole clinical discretion of members of the CHS's professional staff. This staff includes, but is not limited to, registered nurses, nurse practitioners, and physicians.

Student's Date of Birth:_____

Student's UIN:_____

_____ _____

Signature (Parent/Legal Guardian) Date

_____

Parent/Legal Guardian Name (please print)

_____

Phone Number

_____

Alternate Phone Number

(3/3/12)

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