INDIANA UNIVERSITY
BLOOMINGTON

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

Consent for Medical Treatment of a Minor

Name: **UID#:** **Date:**

In order to enable the Health Center of Indiana University and/or other health facilities in Bloomington to provide prompt care to your minor son or daughter, we urge you to read and complete this Consent form. Please return it promptly to 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_____, 19_____

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 of the Directors, 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. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary, including surgery, lab tests, x-ray examinations and 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 for:_____
(Full name of minor)

Date:_____ Signature:_____ (Parent or Guardian)

☐ I authorize limited medical care as follows: _____

to be provided for:_____ (Full name of minor)

Date:_____ Signature:_____ (Parent or Guardian)