

NAME: _____ SESSION(S) _____

CONSENT FOR MEDICAL TREATMENT OF A MINOR

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 the program sponsor. 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)

_____ of _____
(Father/Mother/Guardian) (Full name of minor)

Social Security # _____, a minor age _____, born _____, 19__

Please provide the following information concerning said minor:

Allergic Reactions: _____
Present Medication (if taking, now): _____
Date of Last Tetanus Toxoid: _____
Any past illness or other information that would be useful in the event medical treatment is necessary: _____

IN CASE OF EMERGENCY: Telephone: (Home) _____ / _____
(Work) _____ / _____
Address: _____

Please complete ONE of the following:

- 1. I grant permission to 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. I understand that should a major medical or psychological problem arise, an attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary, including surgery, x-ray examinations, and anesthesia to be rendered to said minor by a licensed physician or nurse.

Date: _____ Signature _____
(Parent or Guardian)

- 2. I do not wish medical care of any kind except emergency care to be provided for: _____
(Full name of minor)

- 3. I authorize limited medical care as follows: _____

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

Date: _____ Signature: _____
(Parent or Guardian)

For Office Use Only: Date Received _____ Confirmation _____