THE UNIVERSITY OF IOWA

Student Health Service
4189 Westlawn
Iowa City, Iowa 52242-1100
319-335-8370 *Fax* 319-335-7247
www.uiowa.edu/~shs

[Patient label goes here] or

Patient's Name_____

Student ID#_____ Date of Birth_____ Age_____

Preferred Name if different from above: _____

PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT MINOR CHILD

Patient/Student Information

Patient/Child Name: _____ Student ID # _____

Local Address: _____ City: _____ State: _____

Local Phone: _____ Cell: _____ Work: _____

Date of Birth: _____/_____/_____

Parent/Guardian Complete the Following

I grant the University of Iowa Student Health Service healthcare providers and staff permission to provide the following for my child should medical attention be necessary while my child is enrolled at the University of Iowa. (mark all that apply)

____ Routine, emergency, or urgent care and treatment
____ Immunizations and skin tests
____ Immunotherapy (allergy shots) and follow up health care
____ Psychiatric care
____ I further give healthcare staff permission to contact my child's primary healthcare provider regarding past medical and medication history, if necessary.

_____
Parent/Guardian Please Print

_____ _____
Parent/Guardian Signature Date

Address: _____

City: _____ State: _____

Phone: (H) _____ (W) _____ (Cell) _____

Comments (continue on back if needed):