THE UNIVERSITY OF TEXAS AT AUSTIN
DIVISION OF STUDENT AFFAIRS
UNIVERSITY HEALTH SERVICES
healthyhorns.utexas.edu

CONSENT FOR TREATMENT OF A MINOR WHO DOES NOT HAVE LEGAL POWER TO CONSENT

Information and Consent

FIRST AND LAST NAME OF MINOR

UT EID OF MINOR

DATE OF BIRTH OF MINOR

HOME PHONE NUMBER OF PARENT/GUARDIAN

WORK PHONE NUMBER OF PARENT/GUARDIAN

I, the undersigned, as the parent or legal guardian of _____ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Austin and is officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any an all claims and causes of action that my arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

SIGNATURE OF PARENT/GUARDIAN

PRINT NAME OF PARENT/GUARDIAN

DATE

Medical Information Related to Minor:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

_____

❑ **Condition was urgent. Parent/guardian consent for treatment was obtained by telephone from:**

NAME OF PARENT/GUARDIAN

TIME AND DATE

HOME PHONE NUMBER OF PARENT/GUARDIAN

TIME AND DATE

SIGNATURE OF STUDENT THAT PARENT/GUARDIAN INFORMATION IS CORRECT

TIME AND DATE