Parental Consent for Treatment

I/We , ,

the [ ] parent(s)
[ ] legal custodian(s);
[ ] legal guardian(s) of the following minor(s):

Student's Name and U number DOB

Hereby give consent for medically necessary treatment, psychological care, psychiatric care including diagnostic procedures, testing including emergency medical treatment by the healthcare providers affiliated with the University of South Florida (USF) Student Health & Wellness, USF Counseling Center, and USF Health. This also includes the USF Bulls County Pharmacy for any medications prescribed as part of the student's medical treatment. I grant permission for the transfer of my student to an acc redited hospital or other care facility if deemed necessary by the medical personnel and hereby authorize my student to sign any necessary consent.

In the event I am not able to be reached and this minor requires medical care, I give the parties listed on the Alternate Parties Authorized to Consent for Medical Care for Minor form the ability to seek and authorize care.

Consent is only valid if signed and dated by the Parent/Legal Custodian/Legal Guardian and a Witness that is over the age of 18.

Signature of Parent/Legal Guardian Date

Print Name of Parent/Legal Guardian

Signature of Witness Date

Print Name of Witness

Please email this completed form to Student Health & Wellness Center