



Parental Consent for Treatment

I/We, ,

the [] parent(s)

[] legal guardian(s);

[] legal guardian(s) for minors):

Student Name and Number

DOB

Hereby give consent for necessary treatment, psychological, psychiatric, and medical services, including emergency treatment, at the University of South Florida (USF) Student Health & Wellness Center, USF Health. This includes the USF Blis Care Physician's services and the student's treatment. I grant permission for the release of information necessary to provide medical services to the student in an emergency without their consent.

In the event that this requires surgery, I give the student the Alternate Parties Authorized to Consent for Medical Care for Minor the by the student.

Consent is valid if signed by the Parent/Legal Guardian and Witness 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 attach to

Student Health & Wellness Center