UHS UNIVERSITY Health Service

# AUTHORIZATION FOR CONSENT TO TREATMENT OF A MINOR

Parent or legal guardian of: _____
Name of Minor (Last, first, middle)

_____ _____
Date of Birth (month/day/year) UMID # or SS #

I consent to University Health Service providing diagnostic and treatment services for my child. I understand that if any invasive or serious procedures are needed I would be contacted in advance of the procedure or service, unless it is an emergency. **Failure to have consent on file except in emergency situations may delay treatment, while we attempt to obtain your consent.**

This consent expires upon the patient's 18th birthday unless revoked in writing.

_____ _____ _____
Print Name of Parent/Guardian Signature Date

_____
Relationship to Student/Patient

Phone Numbers: _____
(Home Number)

_____
(Work Number)

Return this Form by mail to:
University Health Service
HIMS – Form
207 Fletcher Street
Ann Arbor, MI 48109-1050

Or Fax to: 734 936-3063