Authorization to Treat Minors Consent Form

A record of parental or guardian authorization for medical care must be on file to facilitate care for students under the age of 18 years old. Please review the following authorization for treatment and complete the information to authorize treatment for your minor child. Be advised that PHI (Protected Health Information) may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

Authorization

I have the legal right to preauthorize Saint Elizabeth University to deliver medical treatment to my child. I request and authorize Saint Elizabeth University Health Center and its personnel to deliver medical care to my minor child.

_____ _____

Minor Name Date of Birth

Limitations

Identify any limitations on the kinds of medical services for which this authorization is given. If none, please state "NONE":_____

Identify any limitations on the time frame for which this authorization is given. If none, please state "NONE":

_____

Contact Information

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child at the following numbers. If you are unable to contact me for any reason, you may rely on the proxy decision maker for consent.

Parent or guardian name (print) _____

Home phone _____ Work phone _____ Cell phone _____

I wish to delegate the following individual(s) as a decision maker for my minor child.

Proxy name (print) _____

Proxy phone (home/cell) _____

_____ _____

Parent or Legal Guardian Signature Date Witness Signature Date

_____ _____

Print Print