University Health Service
830 South Limestone Street
Lexington, Kentucky 40536-0582

Consent for Treatment of Minor

Parental and/or legal guardian permission for medical examination and treatment by University Health Service or an approved hospital/medical facility.

Student's Name _____
Last First Middle

Date of Birth_____Social Security Number_____

List two persons to be notified in case of emergency. One should be a parent or legal guardian.

1._____ 2._____

Business Phone_____ Business Phone_____

Home Phone _____ Home Phone_____

PARENTAL PERMISSION:

The following consent should be signed by the parent or legal guardian of minors so that appropriate diagnosis and treatment may be given, and so that no unnecessary delays will occur with emergency operative procedures. No operation will be performed, except in an emergency, without a parent or legal guardian being contacted and fully informed if reasonably possible.

I give permission for my son/daughter _____ to receive necessary medical treatment at University Health Service or an authorized hospital/medical facility. I understand that any medical care has risks and benefits, but that these cannot be fully described here in anticipation of a potential for treatment.

Signature_____ Date_____

Relationship to Student _____ Witness _____