University Health Service
830 South Limestone Street
Lexington, KY 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. This consent will expire in one (1) year from date of completion unless written revocation is documented prior to expiration or the patient reaches the age of maturity (18). Annual consent must be completed each year the patient is under the age of (18).

Patient'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.

By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and understand the full import of this grant of powers to University Health Service or an approved hospital/medical facility.

Signature ____________________________ Date _____________________________

Relationship to Student ________________ Witness ____________________________