MEDICAL CONSENT FOR TREATMENT OF A MINOR CHILD UNDER 16

SOUTHERN ILLINOIS UNIVERSITY
STUDENT HEALTH SERVICES

Student Information:

Student Name *(please print)* _____ _____ _____
Last Name First Name Middle Name

Birth Date _____ Dawg Tag # _____

Student Phone Number (_____) _____

Parent/Guardian Information:

Parent/Guardian Name _____ Relationship to Student _____

Country _____ Email: _____

Parent/Guardian Phone Number (_____) _____

I, the parent/legal guardian of _____, hereby authorize and give my express consent to the professional staff of the Student Health Services of Southern Illinois University, Carbondale to provide to my child the following health evaluation, test, or treatment(s): _____

_____

_____

_____

I understand the need for the proposed procedures and have been given an explanation of the benefits and risks of this proposed treatment, alternative treatments, and no treatment. I have been given the opportunity to ask questions and have had them answered.

I also understand that additional fees may be charged for some services and agree to be financially responsible for such charges.

I understand that additional fees, as discussed may be assesed and agree to be financially responsible for such charges.

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____

Relationship to Patient _____

When verbal consent to the above statement is obtained, there must be Signature of two witnesses to the verbal consent and both must sign below.

Signature of Witness 1 _____ Date _____

Signature of Witness 2 _____ Date _____

CONTACT

Student Health Services
374 East Grand Avenue
Mail Code 6740
Carbondale, IL 62901

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Email: shcinfo@siu.edu
Website: shc.siu.edu