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 assessed and agree to be financially responsible for such charges.

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 assessed 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

Phone: 618/453-3311
Email: shcinfo@siu.edu
Website: shc.siu.edu