

FOR UNIVERSITY HEALTH SERVICES USE ONLY	
Patient Name: _____	
Medical Record #: _____	
D.O.B.: _____	Gender: _____
Provider: _____	Date: _____

**CONSENT FOR  
TREATMENT/IMMUNIZATIONS  
OF A MINOR**

University-Sponsored Program Participant  
Information and Consent

Name of Program Participant: \_\_\_\_\_

UTEID (if one has been assigned): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_  
HOME WORK / CELL

I, the undersigned, as the parent or legal guardian of \_\_\_\_\_ (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending provider, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

\_\_\_\_\_  
PRINT NAME

**I have received a copy of University Health Services *Notice of Privacy Practices* as required by HIPAA Privacy Rules.**

\_\_\_\_\_  
SIGNATURE OF PARENT/LEGAL GUARDIAN DATE

\_\_\_\_\_  
PRINT NAME

**Medical Information Related to Minor:**

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

**Please Return to Program Coordinator:**

Name of Program: \_\_\_\_\_

Program Coordinator: \_\_\_\_\_

Coordinator's Phone: \_\_\_\_\_ Coordinator's Fax: \_\_\_\_\_

Coordinator's Mailing Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

