

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 an all claims and causes of action that my 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)