Student Health Center
& Campus Pharmacy
Division of Student Affairs

AUTHORIZATION FOR TREATMENT OF A MINOR

TO BE COMPLETED BY PARENT/LEGAL GUARDIAN

Patient's Last Name	First Name	MI

University ID#	Date of Birth (MM/DD/YYYY)	Age
	/ /	

I, the undersigned, as the parent or legal guardian of the above-named minor and hereby grants permission to the UH Student Health Center to administer recommended immunizations upon request or to carry out indicted medical or surgical tests/treatments. Permission is also granted to the UH Student Health Center to refer the above-named minor to another licensed medical provider or healthcare facility for the necessary continuation of care.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power to UH Student Health Center staff to render necessary care in their best judgment.

This consent shall remain effective from the date signed below until _____ or when the minor becomes 18 years of age.

I hereby certify that I have read the contents of this form or have had it read to me, that the blank spaces have been voluntarily filled in by me, and that I fully understand its contents.

Allergies:	
Current Medications:	
Pertinent Medical History:	

Physical Signature of Parent, Guardian, or Legal Representative (***Electronic or Digital Signatures will not be accepted***)	Date
Print Name	Relationship to Patient

Phone Number	Alternate Phone Number

PERMISSION GRANTED BY PHONE – CLINIC USE ONLY

Signature of Nurse Completing Form	Date	Signature of Witness	Date
Printed Name		Printed Name	

Student Health Center & Campus Pharmacy
Division of Student Affairs

PATIENT ACKNOWLEDGMENT AND CONSENT

Patient Information

Last Name	First Name	Middle Initial

University ID # (PeopleSoft)	Date of Birth (MM/DD/YYYY)
	/ /

By initialing and signing below, I acknowledge that I have read, understand, and agree to the policies and procedures as defined in the Patient Welcome Packet that I received.

Consent to Treat and Health Care Agreement

I acknowledge receipt of and agreement with the Student Health Center's Consent to Treat and Health Care Agreement. uh.edu/healthcenter/forms-policies/treatment-agreement/

Initial

Financial Responsibility Agreement

I acknowledge receipt of and agreement with the Student Health Center's Financial Responsibility Agreement. uh.edu/healthcenter/forms-policies/financial-agreement/

Initial

Notice of Privacy Practices

I acknowledge receipt of the Student Health Center's Notice of Privacy Practices concerning Protected Health Information (PHI). uh.edu/healthcenter/forms-policies/privacy/

Initial

Signature of Patient or Parent/Guardian if patient is a minor	Date
Printed Name	Relationship to Patient