



Parental Consent for Treatment

I/We, ,

the [] parent(s)

[] legal guardian(s);

[] legal guardian(s) for minors):

Student Name and Number

DOB

Hereby give consent for necessary treatment, psychological, psychiatric, and medical services, including emergency treatment, at the University of South Florida (USF) Student Health & Wellness Center, USF Health. This includes the USF Blood Bank Pharmacy which reserves the right to deny treatment if it is necessary for the safety of the individual or if it is necessary to provide necessary medical services to the individual. I give this consent.

In the event that this individual requires care, I give this consent to the Alternate Parties Authorized to Consent for Medical Care for Minor by the individual.

Consent is valid if signed by the Parent/Legal Guardian and Witness is over the age of 18.

Signature of Parent/Legal Guardian

Date

Print Name of Parent/Legal Guardian

Signature of Witness

Date

Print Name of Witness

Please attach to

Student Health & Wellness Center