University of Wisconsin Eau Claire | Student Health Service

Return completed form to:
UW-Eau Claire Student Health Service
Crest Wellness Center 150
630 Hilltop Circle
Eau Claire, WI 54701
(715) 836-5360

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I,_________________________________, being the parent or legal guardian of_____________________ grant the following authorization for medical treatment of this minor by a health care professional should the need arises while they are attending the University of Wisconsin-Eau Claire.

I grant permission to the University of Wisconsin-Eau Claire Student Health Service for evaluation and treatment of medical problems. I understand that should a major medical problem arise; an attempt will be made to notify me by telephone. In the event I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary for said minor by a UW-Eau Claire Student Health Service medical professional.

Parent/Guardian Signature____**Date**__________

Medical Information *(please print):*

Student's Name____Student ID Number____________

Age_____ Birthdate___________________ Date of Last Tetanus Toxoid__________________________

History of Chronic Illness____

History of Surgeries or Hospitalizations____

Medication Allergies____

Present Medication(s) – (attach another sheet, if needed) ______________________________________

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Other information that would be useful in the event medical treatment is necessary_________________

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Insurance Provider__________________________ Insurance Provider Phone Number_______________

Contact Information *(please print):*

In an emergency, parents or legal guardians can be reached as follows:

Name____ Relationship to Minor______________________

Address______________________________________ Daytime Phone__________________________

City/State/Zip__________________________________ Evening Phone__________________________