



UNIVERSITY of ST. THOMAS

Parental Consent Form
University of St. Thomas Student Health Service
Treatment of a Minor

Authorization is hereby given to the University of St. Thomas Health Services, to provide medical care for MINOR'S NAME,

DATE OF BIRTH a minor, in my absence, I may be reached at

PHONE NO. or ALTERNATE PHONE NO. for verification.

This form is valid for all needed medical treatment

for SPECIFIC DATE or DATE to DATE.

Signature (Parent or Guardian)

Date

Street Address

City, State, Zip Code