Millersville University
HEALTH SERVICES

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AUTHORIZATION FOR CONSENT FOR THE TREATMENT OF A MINOR

Parent or legal guardian of: ____ _______________

Name of Minor (Last, First, Middle) Date of Birth

I consent to University Health Services providing diagnostic and treatment services for my child. I understand that if any invasive or serious procedures are needed, I will be contacted in advance of the procedure or services, unless it is an emergency. **I understand that failure to have this consent on file except in emergency situations may delay treatment, while providers attempt to obtain my consent.**

This authorization is effective during my child's time as a student at the university, unless revoked in writing.

_____________________________ _____________________________ _______________________

Print Name of Parent or Guardian Signature Date

_____________________________ ___________________

Relationship to Student/Patient Cellphone Number