



# Parental Consent for Treatment

I/We, ,

- Parent(s)
- Legal guardian(s);
- Legal guardian(s) for minors:

Student Name \_\_\_\_\_ and \_\_\_\_\_ Date of Birth \_\_\_\_\_

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 Blis Care Physician's services and treatment. I understand the risks and benefits of necessary treatment and give my consent.

In the event that this requires surgery, I give consent to the Alternate Parties Authorized to Consent for Medical Care for Minor by the University of South Florida.

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