

Medical Records Department
1109 South Lincoln Avenue
Urbana, IL 61801
Phone (217) 333-2702 Fax (217) 244-6495

<i>place label here</i>
Name: _____
UIN: _____
Date: _____

Authorization and Consent for Treatment of Minors

To be completed by parent or guardian if student is less than 18 years of age when seeking healthcare services from McKinley Health Center at the University of Illinois at Urbana-Champaign.

As the parent/legal guardian of (print student's name): _____,

I hereby authorize and give my express consent to McKinley Health Center for the administration of medical treatment for illness or injury, physical or mental health counseling and routine health maintenance to the above-named student, as deemed necessary in the sole clinical discretion of members of McKinley Health Center's professional staff. This staff includes, but is not limited to, registered nurses, nurse practitioners, physicians, physical therapists, athletic trainers, x-ray technologists and health educators.

Student's Date of Birth: _____

Student's UIN: _____

Signature (Parent/Legal Guardian)

Date

Parent/Legal Guardian Name (please print)

Parent/Legal Guardian Phone Number

Parent/Legal Guardian Alternate Phone Number