FORM # SH101

JOHN A. SWENSON STUDENT HEALTH SERVICES
P.O. Box 9038, Grand Forks, ND 58202
Phone: 701.777.4500 Fax: 701.777.4835

PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT MINOR CHILD[1]

Patient/Student Information

Patient/Child Name: ____**Medical Record #** ______________

Local Address: ___________________________________**City:** ___________________**State:** ______________

Local Phone: _________________________ **W:**______________________ **Cell:** _________________________

Date of Birth: _______/________/19______ **Social Security Number**: ________-_________-________

Parent/Guardian Complete the Following

I grant the University of North Dakota Student Health Services Healthcare Providers, and Staff, permission to provide routine, emergency, or urgent care and treatment, for my child should medical attention be necessary while my child is enrolled at the University of North Dakota. I further give healthcare staff permission to contact my child's primary healthcare provider regarding past medical and medication history, if necessary.

____
Parent/Guardian Please Print

____ ______________
Parent/Guardian Signature **Date**

Address:____

City: ____ **State:** __________________________

Phone: (H) ____________________________ **(W)** ________________________ **(Cell)** _______________________

Comments:

[1] A minor is defined as any student/patient who is under the age of 18. Exceptions to this are made in circumstances in which North Dakota State Law allows minors to seek certain healthcare services without parental consent.

Draft 6/19/03