UNIVERSITY OF
NOTRE DAME
UNIVERSITY HEALTH SERVICES

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AUTHORIZATION FOR CONSENT FOR TREATMENT OF A MINOR

Parent or legal guardian of: _____
Name of Minor (Last, First, Middle)

_____ _____
Date of Birth NDID#

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 service, unless it is an emergency. **Failure to have consent on file except in emergency situations may delay treatment, while we attempt to obtain your consent.**

This consent expires on the patient's 18th birthday unless revoked in writing.

_____ _____ _____
Print Name of Parent or Guardian Signature Date

_____
Relationship to Student/Patient

Phone Numbers: Home:_____ Work:_____

***Upload completed Form to your patient portal at nd.studenthealthportal.com or fax it to: (574) 631-6047