



Parental Consent for Treatment

I/We, _____,

the parent(s)
 legal custodian(s);
 legal guardian(s) of the following minor(s):

Student's name and U-number

DOB

Hereby give consent for medically necessary treatment, psychological care, and psychiatric care including emergency medical treatment by health care providers affiliated with the University of South Florida (USF) Student Health & Wellness, USF Counseling Center, and USF Health. This also includes the USF Bulls Country Pharmacy for any pharmaceuticals prescribed as part of the student's medical treatment.

In the event I am not available at a time this minor requires medical care, I give parties listed on the **Alternate Parties Authorized to Consent for Medical Care for Minor** form the authority to seek and authorize care.

Consent is only valid if signed and dated by both the Parent/Legal Custodian/Legal Guardian and a Witness that 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 mail or fax this completed form to: Student Health & Wellness Center
University of South Florida
4202 East Fowler Avenue, SWC-310
Tampa, FL 33620-6750
Phone: (813) 974-2331
Fax: (813)-974-5888