UNIVERSITY of SOUTH FLORIDA
Student Success
Student Health & Wellness Center

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, psychiatric care including diagnostic procedures, blood testing, imaging and 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. I grant permission for the transfer of my student to an accredited hospital or other care facility if deemed necessary by the medical or mental health provider and for my student to sign any necessary consent.

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