CONSENT FOR MEDICAL TREATMENT OF A MINOR

I,_____, being the parent or legal guardian of_____ grant the following authorization for medical treatment of this minor by a health care professional should the need arises while they are attending the University of Wisconsin-Eau Claire.

I grant permission to the University of Wisconsin-Eau Claire Student Health Service for evaluation and treatment of medical problems. I understand that should a major medical problem arise; an attempt will be made to notify me by telephone. In the event I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary for said minor by a UW-Eau Claire Student Health Service medical professional.

Parent/Guardian Signature_____Date_____

Medical Information *(please print):*
Student's Name_____Student ID Number_____

Tetanus Tntoid