Student Success
Student Health & Wellness Center

Parental Consent for Treatment

I/We, _____,

the [ ] parent(s)
[ ] legal custodian(s);
[ ] legal guardian(s) for the following minor(s):

_____
Student's Name and Number DOB

Hereby give consent for the medical treatment, psychological care, psychiatric care including diagnostic procedures, the testing and emergency medical treatment by the healthcare providers affiliated with the University of South Florida (USF) Student Health & Wellness, USF Counseling Center, and USF Health. This also includes the USF Bulls County Pharmacy and other ancillary services related to the student's medical treatment. I grant permission for the transfer of my student to an acute care facility if deemed necessary by the medical personnel at the above mentioned facility. My student may sign any necessary consent.

In the event I am unable to be reached or is incapacitated and my child requires medical care, I give the person listed on the Alternate Parties Authorized to Consent for Medical Care for Minor form the authority to seek and approve care.

Consent is only valid if signed and dated by the Parent/Legal Custodian/Legal Guardian and a Witness who 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 email this completed form to Student Health & Wellness Center