



Parental Consent for Treatment

I/We, ,

- Parent(s)
- Legal guardian(s);
- Legal guardian(s) for minors:

Student Name _____ and _____ Date of Birth _____

Hereby give consent for necessary treatment, psychological, psychiatric, and medical services, including emergency treatment, at the University of South Florida (USF) Student Health & Wellness Center, USF Health. This includes the USF Blis Care Physician's services and treatment. I understand the risks and benefits of necessary treatment and give my consent.

In the event that this requires surgery, I give consent to the Alternate Parties Authorized to Consent for Medical Care for Minor by the above.

Consent is valid if signed by the Parent/Legal Guardian and Witness 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 attach to _____ Student Health & Wellness Center