



John A. Swenson Student Health Services
 McCannel Hall, Room 100
 2891 2nd Avenue N., Stop 9038
 Grand Forks, ND 58202-9038
 Phone: 701.777.4500 Fax: 701.777.4835

Medical Record # _____

CONSENT TO TREAT MINOR CHILD¹ – PARENT/GUARDIAN AUTHORIZATION

Patient Information

Patient/Child Name: _____

Local Address: _____

City: _____ State: _____ Zip Code: _____

Local Phone: _____ W: _____ Cell: _____

Date of Birth: _____ / _____ / _____ UND ID# _____

Parent/Guardian - Complete the Following

I grant the University of North Dakota Student Health Services healthcare providers and other licensed healthcare staff permission to provide routine, urgent, or emergency care and treatment for my child should medical attention be necessary at the University of North Dakota. I further give healthcare staff permission to contact my child's primary healthcare provider regarding past medical and medication history, if necessary.

Parent/Guardian
 (Print)

Relationship to Minor

Parent/Guardian
 (Signature)

Date

Parent Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (H) _____ (W) _____ (Cell) _____

Comments:

¹A minor is defined as any patient who is under the age of 18. Exceptions to this are made in circumstances in which North Dakota State Law allows minors to seek certain healthcare services without parental consent.