University Health Services
University of Cincinnati
PO Box 210010
Cincinnati, Ohio 45221-0010

Lindner Athletic Center, 3rd floor
(513) 556-2564 Phone
(513) 556-1337 Fax

FOR STUDENTS UNDER 18 YEARS OF AGE
PARENTAL CONSENT FOR TREATMENT

I, the undersigned, authorize the physicians of University Health Services of the University of Cincinnati, to treat my son/daughter. This authorization covers the visit and any care deemed necessary by the treating physician.

This authorization is good for the academic year _____.

PLEASE PRINT:

Student's Name: _____
(last) (first)

Student's Date of Birth: _____

Student's Social Security Number: _____

Signature of Parent/Guardian: _____

Parent's/Guardian's Phone number: _____

NOTE:

Students are responsible for any charges not covered by their specific health insurance plan.