Health, Counseling and Disability Access Services
131 Millennium Student Center
One University Blvd.
St. Louis, Missouri 63121-4400
Phone: 314-516-5671

Consent for Medical Treatment – Minor Child or Dependent Adult

I, _____ (print name here), am the parent/guardian of _____ (print name of student), currently a minor/dependent adult, whose date of birth is _____ / _____ / _____.

I authorize University Health, Counseling & Disability Access Services at the University of Missouri - St. Louis to provide medical and/or mental health care to the above named student including, but not limited to, diagnostic examinations (including laboratory testing), tuberculosis screening, verification and/or administration of immunizations, any necessary medical treatment, and mental health counseling.

I also understand that if an injury/illness is determined to be life threatening that an ambulance will be called to take the dependent adult/minor child to the hospital and that the provider will make every effort to contact me.

I further understand that once my minor child reaches the age of maturity, my consent for treatment is no longer required. This does not apply for dependent adults.

By signing this I acknowledge that I have read and understand this consent, and that any questions I had prior to signing could be answered by calling University Health Services at 1-314-516-5671.

_____ _____
Signature Date

Emergency Phone Numbers:
_____ Home
_____ Cell
_____ Work
_____ Other Contact information