University of North Dakota

JOHN A. SWENSON STUDENT HEALTH SERVICES
P.O. Box 9038, Grand Forks, ND 58202
Phone: 701.777.4500 Fax: 701.777.4835

Medical Record #: _____

CONSENT TO TREAT MINOR CHILD[1]-PARENT/GUARDIAN AUTHORIZATION

Patient/Student Information

Patient/Child Name: _____

Local Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Local Phone: _____ **W:**_____ **Cell:** _____

Date of Birth: _____/_____/19_____ **Social Security Number:** _____-_____-_____

Parent/Guardian Complete the Following

I grant the University of North Dakota Student Health Services healthcare providers, and other healthcare staff (nursing, pharmacy, and lab), permission to provide routine, emergency, or urgent care and treatment, for my child should medical attention be necessary while my child is enrolled 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 Student**

_____ _____

Parent/Guardian (Signature) **Date**

Parent Address:_____

City: _____ **State:** _____ **Zip Code:**_____

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

Comments:

[1] A minor is defined as any student/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.