WELLNESS CENTER

PARENTAL CONSENT FOR TREATMENT & CARE OF MINORS

I, _____, being the parent and/or legal Guardian of the minor age child, _____, hereby give consent for medically necessary treatment and care, including emergency treatment, by the health care providers affiliated with the University Of South Florida St. Petersburg Wellness Center, College Of Medicine and the USF Physicians Group. In the event I am not available at a time this minor requires medical care, I give the parties listed below the authority to seek and authorize care.

This consent will remain in effect until I sign a written revocation.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Witness Date

Alternate Parties Authorized to Seek Medical Care for Minor Child

1._____ _____

Printed Name Relationship

Work Phone:_____Home Phone:_____Initial of Legal Guardian:_____

2._____ _____

Printed Name Relationship

Work Phone:_____Home Phone:_____Initial of Legal Guardian:_____

3._____ _____

Printed Name Relationship

Work Phone:_____Home Phone:_____Initial of Legal Guardian:_____

Patient Name:_____DOB:_____ U-_____