

UCR Health Centers  
Parent or Guardian Consent for Medical Treatment of a Minor

To the best of my knowledge, my child is in good health. In the event of circumstances which indicate that my child is in need of medical care, I authorize, on my behalf \_\_\_\_\_ (name) to consent to any necessary first aid or medical care in accordance with standard medical practice by licensed medical personnel.

Mother's Name	Home Address	
Father's Name	City	State
Guardian's Name	Zip Code	
Home Telephone Number	Work Telephone Number	
<b>EMERGENCY INFORMATION</b>		
Child's Physician	Phone No.	
Preferred Hospital		
Insurance Company		
Policy No.		
Insurance Phone Number		

<b>MEDICAL INFORMATION</b>
Major Illnesses or injuries:
My/Our child is allergic to:
My/Our child takes these medications
Immunizations are up-to-date: YES / NO
Other relevant information:

Signature of Parent:	Date:
Printed Name:	
Signature of Legal Guardian:	Date:
Printed Name:	

**FOR STAFF USE:**

Received by:	Date:
Staff Signature:	