



Health Services
(phone) 630-844-5434
(fax) 630-844-5611

Minor Consent Form for Health Services

Clinic Visit Date:

Check-in Time:

Minor Student's Name _____

Date of Birth _____ Age _____

Phone _____ Email _____

TELEPHONE CONSENT:

Parent/Guardian (name and relationship):

_____,
consents to the assessment and treatment of their son/daughter per the protocols of
Aurora University Health Services on this date.

(RN Signature) Date _____

Parent/Guardian Phone Number: _____

Signature of parent/guardian, if present at visit:
