Aurora University Health Services

Phone: 630-844-5434
Fax: 630-844-5611

Minor Consent Form

Student's Name _____ **Date of Birth/Age** _____ **Student ID #**_____

Parent/Guardian Name _____ **Relationship** _____

Parent/Guardian Phone Number _____

I, _____ (Parent/Guardian's Name), hereby consent to the assessment and treatment of _____ (Student's Name), per the protocols of Aurora University Health Services.

Duration of this Consent:

- ☐ For this visit only
- ☐ This authorization will remain in effect until 18th birthday of listed minor, unless sooner revoked in writing and delivered to Aurora University Health Services
- ☐ This authorization shall remain in effect until _____, 20___, unless sooner revoked in writing and delivered to Aurora University Health Services.

Signature of Parent/Guardian _____ Date/Time_____

Health Services Staff Signature _____ Date/Time_____

Telephone Consent from Parent/Guardian – Health Services Staff Use Only

I have obtained telephone consent for Aurora University Health Services to assess and treat the minor student after speaking with the student's parent/guardian, as listed above. This consent will remain in effect for the duration of consent, as specified above.

Persons Obtaining Telephone Consent:

Health Services Staff Name/Signature _____ Date/Time _____

Health Services Staff Name/Signature _____ Date/Time _____