

**CONSENT FOR TREATMENT OF A MINOR WHO DOES NOT HAVE LEGAL POWER TO CONSENT**  
**Information and Consent**  
**Parent/Guardian**

\_\_\_\_\_  
FIRST AND LAST NAME OF MINOR

\_\_\_\_\_  
MYUTSA ID or Banner ID #

\_\_\_\_\_  
DATE OF BIRTH OF MINOR

\_\_\_\_\_  
HOME PHONE NUMBER OF PARENT/GUARDIAN

\_\_\_\_\_  
WORK PHONE NUMBER OF PARENT/GUARDIAN

I, the undersigned, as the parent or legal guardian of \_\_\_\_\_  
(a minor) hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for treatment of any illness or injury of the minor. The provider, appropriate staff, and The University of Texas at San Antonio and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical, and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
PRINT NAME OF PARENT/GUARDIAN

\_\_\_\_\_  
DATE

**Medical Information Related to Minor:**

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_

Pertinent Medical History: \_\_\_\_\_

\_\_\_\_\_  
**Clinic Use Only**  
\_\_\_\_\_

**Condition was urgent. Parent/guardian consent for treatment was obtained by telephone from:**

\_\_\_\_\_  
NAME OF PARENT/GUARDIAN

\_\_\_\_\_  
TIME AND DATE

\_\_\_\_\_  
HOME PHONE NUMBER OF PARENT/GUARDIAN

\_\_\_\_\_  
TIME AND DATE

\_\_\_\_\_  
SIGNATURE OF STUDENT THAT PARENT/GUARDIAN INFORMATION IS CORRECT

\_\_\_\_\_  
TIME AND DATE