UT HEALTH WELLNESS 360 at UTSA

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 is 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

TEXAS FAMILY CODE 32.003-.004