

Patient Name: _____	
UT Arlington I.D. #: _____	
D.O.B.: _____	Gender: _____
Provider: _____	Date: _____

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

Name of Minor: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address (Street, City, State, Zip Code): \_\_\_\_\_

\_\_\_\_\_

Parent/Guardian Phone Number: \_\_\_\_\_  
HOME
WORK

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 the treatment of any illness or injury of  
the minor. The attending physician, appropriate staff, and The University of Texas at Arlington 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 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/LEGAL GUARDIAN

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINT NAME

Medical Information Related to Minor:

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

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

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

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

CONDITION WAS URGENT. Parental/guardian consent for treatment was obtained by telephone from:

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

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

By \_\_\_\_\_  
SIGNATURE OF NURSE OBTAINING CONSENT