



University of Texas Arlington Health Services

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www.uta.edu/healthservices

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 _____