# Authorization and Consent for Medical Treatment of a Minor at Texas Woman's University

**Complete and mail or fax to:**
Student Health Services Fax: (940) 898-3844
P.O. Box 425467 Phone: (940) 898-3826
Denton, TX 76204-5467 (888) 898-8825

**Authorization and Consent:**

I hereby give my consent for medical treatment of _____, who is _____ years of age, in the event that such treatment becomes necessary. I grant my permission for treatment at Texas Woman's University Student Health Services by a licensed physician, licensed nurse practitioner, and/or designees, including such personnel as the physician may deem necessary. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice.

This consent will be in effect from this date until minor is 18 years of age unless cancelled earlier by me in writing.

**Date** _____ **Signature** _____
**(Parent or Guardian)**

**Student's Full Name** _____
**(Last)** **(First)**

**Address** _____

***Telephone Where Parent or Guardian May Be Reached:***

**Mother/Guardian**

Home: (____) _____ Business/Mobile: (____) _____

**Father/Guardian**

Home: (____) _____ Business/Mobile: (____) _____

**Student's Birth date:** _____ **Student Social Sec. Number:** _____

**Allergies to Medication or Foods:** _____

_____

**Medications Currently Taking:** _____

_____

**Any other pertinent medical information:** _____

_____