THE UNIVERSITY OF TEXAS
GLOBAL ETHICS & CONFLICT RESOLUTION SUMMER SYMPOSIUM

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CONSENT FOR TREATMENT OF A MINOR
PLEASE PRINT LEGIBILY

Name of Student: ____
FIRST MIDDLE INITIAL LAST

Social Security Number:________-________-____________ ***Date of Birth:*** _______________

Address: ____

____
CITY: STATE: ZIP:

Parent/Guardian Name(s): ____

Phone Number(s)

____
HOME WORK MOBILE

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 Austin 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. I understand that I will be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.
I have also received a copy of University Health Services Notice of Privacy Practices.

Signature of Parent/Legal Guardian:______________________________________ ***Date:***____________

PERTINENT MEDICAL/INSURANCE INFORMATION
(To be completed by parents/guardians)

Medical: ____

Allergies: ____

Current Medications: ____

Other: ____

Insurance Company: ____

Policy #: ____

Social Security or ID #: ____