



Return completed form to:
UW Oshkosh Student Health
800 Algoma Blvd., Radford Hall
Oshkosh, WI 54901-8694



CONSENT FOR MEDICAL TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of _____ grant the following authorization for medical and treatment of this minor by a health care professional should the need arise while he/she is attending the University of Wisconsin Oshkosh.

I grant permission to the University of Wisconsin Oshkosh Student Health Center for evaluation and treatment of medical problems. I understand that should a major medical problem arise, an attempt will be made to notify me by telephone. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary for said minor by a licensed physician or nurse.

Date _____ Parent/Guardian Signature _____

Medical Information (please print):

Student's name: _____ Student ID: _____

Age: _____ Birth date: _____ Date of last Tetanus Toxoid: _____

History of Chronic illness: _____

History of surgeries or hospitalizations: _____

Medication allergies: _____

Present medication (attach another sheet if needed): _____

Other information that would be useful in the event medical treatment is necessary:

Insurance Carrier: _____ Insurance Phone Number: _____

Contact Information (please print):

In an emergency, parents or legal guardians can be reached as follows:

Name: _____ Relationship to minor: _____

Address: _____ Daytime phone: _____

City/State/Zip: _____ Evening phone: _____