STUDENT HEALTH & WELLNESS

The University of Iowa * 4189 Westlawn * Iowa City, IA 52242 * Ph. 319-335-8370

[Patient label goes here] or

Patient's Name_____

Student ID#_____ Date of Birth_____ Age_____

Preferred Name if different from above: _____

PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT MINOR CHILD

Patient/Student Information

Patient/Child Name: _____ Student ID # _____

Date of Birth: _____/_____/_____
month/ day /year

Parent/Guardian Complete the Following

I grant the University of Iowa Student Health & Wellness healthcare providers and staff permission to provide medical care for my student should this be necessary while enrolled at The University of Iowa.

_____
Parent/Guardian Please Print

_____ _____
Parent/Guardian Signature Date (month/day/year)

Street Address: _____ Country: _____

City: _____ State: _____

Phone: (Home) _____ (Work) _____ (Cell) _____

Email address: _____

Please scan and e-mail to: student-health@uiowa.edu OR Fax to: 319-335-7247.

International Students: Please scan and email to: internationalforms@uiowa.edu OR FAX to 319-335-7247.