STUDENT HEALTH

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

PARENT/GUARDIAN AUTHORIZATION/CONSENT TO TREAT MINOR STUDENT

Student Name: _____ **Student ID #** _____

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

Parent/Guardian Complete the Following

I grant the University of Iowa Student Health 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.

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