University of Northern Iowa
Student Health Clinic

Consent for Treatment of a Minor Child

Student's Name: ____

Student's Date of Birth: _______________ Student ID#:__________________

Parent/Guardian

To assist us in caring for your minor child we request that a parent or guardian sign the authorizations on this form and return it to us promptly. Iowa law mandates that in order to provide medical or mental health treatment of a minor (under 18), the consent of a parent or guardian is required.

I give permission to the University of Northern Iowa Student Health Clinic to provide treatment for my child.

Parent/Guardian Printed Name: ____

Parent /Guardian Signature: ____

Relationship :(Parent/Guardian)____________________Date:_________________

Student

I authorize the University of Northern Iowa Student Health Clinic to contact my parent/guardian to discuss and consent to my medical or mental health treatment.

Student Printed Name: ____

Signature name: _________________________________Date:_________________

Please return completed form to:

UNI Student Health Clinic
016 Student Health Center
Cedar Falls, IA 50614-0221
Fax: 319-273-7030
Email: healthcenter@uni.edu

In office use only:

Verbal phone consent witnessed: _________________________RN____ Date__________

Verbal phone consent witnessed: _________________________RN____ Date__________

Healthcare provider's signature: _______________________________ Date__________