Student Health Services

FLORIDA INTERNATIONAL UNIVERSITY

**CONSENT FOR TREATMENT OF A MINOR**

**CONSENT BY PARENT/LEGAL GUARDIAN**

**I, the undersigned, as parent or legal guardian of:**

**Student's Name: ________________________________ Date of Birth: _______________________**

**Panther ID: ____________________________________**

**have the legal authority to give consent for the treatment of this minor. I hereby authorize Student Health Services, Florida International University, to provide such diagnostic or medical treatment to such minor as may be considered necessary or appropriate under the circumstances which may include, without limitation, arranging for and/or authorizing consultation, evaluation, referral, treatment, including medication and/or vaccine administration, for the above named minor. I agree that treatment may be provided in my absence. This consent shall remain in effect unless it is revoked in writing.**

**Signature:________________________________signed this______day of___________, 20_______**

**Parent/Guardian Name (Print): ________________________________________________________**

**Relationship to Minor: ______________________________________________________________**

**Address:_____________________________________________________________________________**

**Phone: (_______)___________________**

***Please attach a copy of the parent/guardian valid ID or driver's license this consent form.**

**Return form to:**

**FIU - Student Health Services**
**Medical Records**
11200 S.W. 8 Street, SHC Room 150
Miami, FL 33199
Phone: (305) 348-0316
Fax: (305) 348-0336
Email: medrec@fiu.edu