



University Health Services
University of Cincinnati
PO Box 210010
Cincinnati, Ohio 45221-0010

Lindner Athletic Center, 3rd floor
(513) 556-2564 Phone
(513) 556-1337 Fax

**FOR STUDENTS UNDER 18 YEARS OF AGE
PARENTAL CONSENT FOR TREATMENT**

I, the undersigned, authorize the physicians of University Health Services of the University of Cincinnati, to treat my son/daughter. This authorization covers the visit and any care deemed necessary by the treating physician.

This authorization is good for the academic year _____.

PLEASE PRINT:

Student's Name: _____
(last) (first)

Student's Date of Birth: _____

Student's Social Security Number: _____

Signature of Parent/Guardian: _____

Parent's/Guardian's Phone number: _____

NOTE:

Students are responsible for any charges not covered by their specific health insurance plan.