KENT STATE UNIVERSITY | University Health Services

Parental Consent

Parental/Guardian Consent for Treatment of a Minor

(If student will be under 18 at arrival on campus)

STUDENT NAME: _____DOB: _____

Kent State ID#: _____

I hereby authorize the professional staff of Kent State University Health Services to carry out or to request such diagnostic and therapeutic measures for my son/daughter as may be considered necessary or advisable by the treating provider. I also authorize the release to other providers who may be treating my son/daughter, relevant medical information as to treatment provided my son/daughter through University Health Services. I understand I will be notified as soon as possible in the event of life-threatening illness or injury.

Signature of Parent or Legal Guardian: _____

Print Name:_____

Phone #:_____

Date: _____

Please return this form to:

Kent State University
University Health Services
1500 Eastway Drive
Kent, OH 44242