



CONSENT TO TREAT MINOR CHILDREN AT
UNIVERSITY HEALTH SERVICES MANOA

To be completed by Parent or Legal Guardian if the student is under the age of 18 when seeking health services from the University.

I, the parent/legal guardian of _____ (print student's name), in consideration of the services rendered by the University Health Services Manoa (UHSM), hereby voluntarily and knowingly, authorize and give my express consent to *UHSM* for the administration of TB tests, immunizations, medical treatment for illnesses or injuries, and emergency care to the above-named student as deemed necessary by the *UHSM* staff.

Parent/Legal Guardian Signature: _____ Date: _____

Print Last Name, First Name: _____