Mail or Fax Form to:
Leeward Community College
Student Health Center
96-045 Ala Ike, Pearl City, HI 96782-3393
Phone (808) 455-0515 Fax (808) 455-0267

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS

NAME: _____ UH STUDENT ID#: _____
Last (Family Name) First Middle

DATE OF BIRTH: ____/____/____ SEX: F / M UH EMAIL ADDRESS: _____

IN CASE OF EMERGENY NOTIFY NAME: _____

RELATIONSHIP: _____

PHONE: (H) (____) _____ (W) (____) _____ (CELL) (____) _____
Area Code Area Code Area Code

AUTHORIZATION AND CONSENT FOR TREATMENT OF MINORS – To be completed by a parent or guardian if the student will be under the age of 18 when seeking health services from Leeward Community College.

I, the parent/legal guardian of (PRINT STUDENT NAME) _____, in consideration of the services rendered and of the facilities provided by Student Health Center, hereby voluntarily and knowingly authorize and give my express consent to visit, or visits when either unaccompanied or accompanied by myself or another adult while in transit to, from, or in attendance at Leeward Community College, for the purpose of clinical observation, and/or the administration of such treatment, and the taking of whatever X-Rays, injections, or drugs that may be considered necessary or desirable in the observation, diagnoses, and treatment of his/her case by the physician in attendance and/or the staff of the Student Health Center.

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____ DATE: _____