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Advance Consent to Treat Minors

If the student will be attending the University of Idaho and is under age 18, we will need a parent or guardian authorization to be able to evaluate and treat them at the Student Health Clinic. Please print the names then sign and date below.

I, _____, the parent or legal guardian of my child, _____, date-of-birth ____/____/____, authorize and consent to routine and emergency medical treatment for my child when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

Signature of parent/legal guardian

Date