IUPUI

CAMPUS HEALTH

INDIANA UNIVERSITY-PURDUE UNIVERSITY
Indianapolis

PARENTAL AUTHORIZATION AND CONSENT FORM

This form is signed by the parent or guardian of the named individual who has not yet attained the age of 18. It permits a physical evaluation, which includes immunizations, tests and treatment including work and non-work related injuries or illnesses.

I hereby authorize the physicians, agents and employees of IUPUI Campus Health to carry out the following services and treatment on my child:

______________________________ ____________________

Name | Birthdate (mo/day/yr)

I. Evaluation and Treatment

Medical and surgical care and services, including, but not restricted to: preplacement evaluation, diagnostic tests, examination and other medical and surgical procedures that are adjudged by the physician and/or nurse practitioner to be necessary for the diagnosis and treatment of an illness or condition, whether or not arising out of employment.

I do also hereby authorize the release of medical record information related to the diagnosis and treatment, as the parent and/or guardian of the above named individual, to third party payers, institutions, or other physicians or providers who may render services or provide payment for my child's healthcare.

____________________ ____________________ ______________

Printed Name of Parent/Guardian | Signature | Date

II. Statement of Individual

I understand that my medical records are available to my parent and/or guardian until my 18th birthday.

____________________ ____________________ ______________

Printed Name of Patient | Signature | Date

A 27.1 Attachment A

2/17/17lab

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Indiana University—Purdue University Indianapolis