ILLINOIS
McKinley Health Center

place label here

Name:

UIN:

Date:

Medical Records Department
1109 South Lincoln Avenue
Urbana, IL 61801
Phone (217) 333-2702 Fax (217) 244-6495

Authorization and Consent for Treatment of Minors

To be completed by parent or legal guardian of student less than 18 years of age seeking healthcare services from McKinley Health Center at the University of Illinois at Urbana-Champaign.

As the parent/legal guardian of (print student's name):_____,
I hereby authorize and give my express consent to McKinley Health Center for the administration of medical care and treatment to the above-named student. Medical care and treatment includes, but is not limited to, physical examinations, treatment for illnesses or injuries, diagnostic laboratory testing, radiology services and required, recommended or requested immunizations/vaccinations. This consent is valid until revoked in writing by the parent or legal guardian or is no longer necessary under the law.

Student's Date of Birth:_____

Student's UIN:_____

_____ _____
Signature (Parent/Legal Guardian) Date

_____
Parent/Legal Guardian Name (please print)

_____
Parent/Legal Guardian Phone Number

_____
Parent/Legal Guardian Alternate Phone Number