# Consent for Treatment of Minors

Please complete for all students/clients under the age of 18 and return to *University Health Care* *on the appropriate campus*. Please print names legibly.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, parent or legal guardian of

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize University Health Care of Pace University, its clinical services, nursing and medical staff to administer such diagnostic procedures and provide such health care as deemed necessary or advisable in the judgment of the attending nurse practitioner.

I confirm that I fully understand the above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent/Legal Guardian** Date

Permanent address: Residence Hall:

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Telephone Number:

Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❒ New York City ❒ Westchester

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University Health Care University Health Care

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