

University of Iowa Sports Medicine



Parent/Guardian Authorization/Consent to Treat Minor Child

Patient/Student Information

Patient/Child Name

Student ID #

Local Address

City

State

ZIP Code

Country

Home Phone

Cell Phone

E-mail

Date of Birth

Patient/Guardian Complete the Following

I grant the University of Iowa Athletic Training Services and UI Sports Medicine healthcare providers and staff permission to provide the following for my child should medical attention be necessary while my child is enrolled at the University of Iowa. (mark all that apply)

Routine, emergency, or urgent care and treatment

I further give healthcare staff permission to contact my child's primary healthcare provider regarding past medical and medication history if necessary

Immunizations and skin tests

SHIP Insurance plan to assist in covering expenses for athletic related medical expenses

Immunotherapy (allergy shots) and follow up health care

Psychiatric care

Parent/Guardian Address

City

State

ZIP Code

Country

Home Phone

Cell Phone

Work Phone

E-mail

Relationship to Athlete

Parent/Guardian Name (Please Print)

Date

Parent Guardian Signature

Please complete this electronic form, print, sign, and return to insurance coordinator Chris Slauson.