THE UNIVERSITY OF RHODE ISLAND
DIVISION OF STUDENT AFFAIRS

Authorization For Medical Care and Treatment of a Minor

UPLOAD THIS FORM IN THE PATIENT PORTAL BY VISITING: HEALTH.URI.EDU

THINK BIG WE DO℠

DR. PAULINE B. WOOD HEALTH SERVICES
6 Butterfield Road, Potter Building, Kingston, RI 02881 USA p: 401.874.2246 f: 401.874.2586 http://health.uri.edu

NOTE: This consent form only needs to be completed and uploaded if the student is a minor (under 18 years of age). For all minors, a signed authorization by parent/guardian is required prior to treatment at URI Health Services.

Student Name: _____

Date of Birth: _____

Student ID #: _____

Student Cell Phone #: _____

PARENTS / GUARDIANS OF STUDENTS UNDER 18 YEARS OF AGE
PLEASE COMPLETE THIS SECTION

I hereby grant permission to University of Rhode Island Health Services to provide any medical treatment for my son/daughter _____ deemed necessary by the Health Services staff.
STUDENT'S NAME

I understand that every effort will be made to notify me in the event of major illness or injury.

_____ _____
PARENT/GUARDIAN SIGNATURE DATE

_____ _____
PRINT NAME PARENT/GUARDIAN CELL PHONE NUMBER

_____
RELATIONSHIP TO STUDENT