

Authorization For Medical Care and
Treatment of a Minor

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

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 will be a minor (under 18 years of age) when they arrive at URI. 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