Medical Treatment Authorization Form for Minor Students

I/We, the undersigned, parent(s)/legal guardian of ________________________________________,
(Your child’s full name)

A minor, do hereby authorize the staff of Augusta University Student Health Services permission to
provide any necessary or beneficial medical treatment to my child while he/she is attending school at
Augusta University. Medical care includes but is not limited to: venipuncture (blood draws),
immunizations (shots), general physical examinations, referral for diagnostic testing such as x-rays,
referrals to specialists for care and any treatment that is necessary and possibly beneficial for my child.

I understand that additional charges may be incurred for medical care and these charges may not be
covered by the Student Health Fee. Additional charges will be the responsibility of the
parent/guardian of patient or patient.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or
hospital care being required, but is given to provide authority and power on the part of the Augusta
University Student Health provider in the exercise of his/her best judgment may deem advisable and
release Augusta University Student Health from all damages of same.

____________________                     ___________________                     ___________________
(Print) Parent/Guardian                         Parent/Guardian Signature          Date
Name

My relationship to the student/patient is (please circle one):   Parent    Legal Guardian

____________________                     _____________________                     _____________________
(Print) Witness Name   Witness Signature          Date

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