

Marquette University
Parental Consent for Care of Students Under Age 18

Print this form and have a parent or legal guardian complete the form

The law requires that a parent/guardian grant permission for medical evaluation and/or treatment of minors (anyone under 18 years of age).

The following consent must be signed by a parent/guardian of a minor so that he/she may receive medical evaluation/treatment. No major medical or surgical procedure will be performed, except in an emergency, without the parent/guardian first being contacted.

Student Name: _____ **MUID:** _____

Authorization:

I concur with the above and authorize, at the discretion of MU Medical Clinic personnel, medical and surgical care including examinations, treatments, immunizations and the like for my son or daughter. In the event of serious disease or injury or the need for major surgery, I understand that all reasonable efforts will be made to contact me, but that failure to make contact will not prevent emergency treatment necessary to help preserve life or health.

Parent/Guardian Name: _____

Home Phone: (____) _____

Work Phone: (____) _____

Mobile Phone: (____) _____

Signature of Parent/Guardian: _____

Date: ____/____/____
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When this form is complete, the student must send this form to Marquette University Medical Clinic by mail, e-mail or fax.

Mail to: MU Medical Clinic
Marquette University
P.O. Box 1881
Milwaukee, WI 53201-1881

Or e-mail scanned attachment to:
immunizations@marquette.edu
Or fax to:
(414) 288-1664

Please allow three business days to review your form. Questions? Contact us at immunizations@marquette.edu or (414) 288-7184.