UF UNIVERSITY of FLORIDA
The Foundation for The Gator Nation

# Parental/Guardian Authorization for Treatment of Minors (under age 18)

## Section 1—TREATMENT AUTHORIZATION

I authorize the provision of medical or hospital care deemed necessary for:

Name: _____ ρ Male ρ Female
First Middle Initial Last

Date of Birth: / /

In the event an illness or injury occurs during his or her volunteer service to the University of Florida, I further authorize each of the following:

- I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.
- I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

## Section 2—PHYSICIAN/EMERGENCY CONTACT INFORMATION

**Family Physician**
Name: _____ Phone: _____

**Emergency Contact**
Name: _____ Phone: _____

Address: _____

## Section 3—PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

**Signature:** _____ **Date:** _____

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

**Signature:** _____ **Date:** _____

## Section 4—TO BE COMPLETED BY THE DEPARTMENT *Department documentation for telephone authorization*

Person Contacted: _____ Phone: _____

Relationship to Volunteer: _____

Witnesses: _____

Description: _____

_____

_____

Date: _____ Time: _____

*This form should be maintained by the department in which the volunteer will work.*