UF Human Resources
Classification & Compensation

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 of injury occurs during their 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 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: _____

Phone #: _____ Work Phone #: _____

Address: _____

Signature: _____ **Date:** _____

Name of Parent or Guardian: _____

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: _____