

UNIVERSITY OF ARKANSAS

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Pat Walker Health Center - (PWHC)
Division of Student Affairs

AUTHORIZATION FOR TREATMENT OF A MINOR

NAME: _____ SS#: _____

MEDICATION/ALLERGIES: _____

AGE: _____

1. Is he/she taking any medication on a regular basis? _____
If yes, what? _____

2. Is he/she under a doctor's care at this time for any medical problem? _____
If yes, what? _____

Name of physician _____ Phone # _____

3. Does he/she have any chronic medical problems? (Asthma, diabetes, epilepsy, etc.)

4. Has he/she had a close relative die from a heart attack before the age of 40? _____

5. Does he/she have a history of a head injury resulting in a loss of consciousness? _____

6. Does he/she have a history of mental health problems? _____
If yes, what? _____

7. Date of last Tetanus shot: _____

8. Other Comments: _____

I hereby grant permission for my child to undergo examination and receive medical care and/or treatment if necessary by the University of Arkansas - Pat Walker Health Center professional staff.

Signature of Parent or Guardian: _____

Date: _____

Home Phone: _____ Work Phone: _____