FELICIAN UNIVERSITY

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Parental Consent Form
(Students under 18 years of age)

Please Print

I (parent/guardian) _____am the legal parent/guardian of (student's name) _____.

I hereby request that my son/daughter be treated at the Felician University Center for Health if the need arises.

My son/daughter has been given information on the services available. We have had a chance to ask questions that were answered to our satisfaction.

I am aware of the benefits and risks of the services and I authorize the Felician University Center for Health to provide services to my son/daughter.

I understand that I will be contacted for my guidance at the below phone number(s), prior to services being provided.

I do not hold the Felician University Center for Health or any of its' employees responsible for any untoward effects from receiving the treatment.

Signature _____ Date _____

Phone_____Alternate Phone_____

Address _____

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