SP HEALTH CLINIC

Parental Consent Form

I, _____, the parent or legal guardian of
Parent or Legal Guardian Full Name

_____, do hereby give consent to any medical
Students Full Name

care and advice determined by the professional medical provider of SP Health Clinic for the welfare of my child while under the supervision of Hawaii Pacific University while I am not physically present.

This authorization is in effect on _____/_____/_____ and shall remain in effect until the student is at the legal age of 18 years old or until I provide a written statement requesting so to the clinic.

By signing below, I, as the parent or legal guardian of the student, understand that this may include prescribing medication, additional tests or exams such as x-ray or laboratory tests, or sending for outside care if the student requires a higher level of medical care.

Parent or Legal Guardian Information

Best Contact Number: (_____)_____

Secondary Contact Number: (_____)_____

Email Address:_____

_____ _____

Parent or Legal Guardian Signature **Date**

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