



Habif Health and  
Wellness Center

STUDENT AFFAIRS AT WASHINGTON UNIVERSITY

## **Habif Medical Health Services Parental Consent Form**

I, \_\_\_\_\_, as legal custodial parent/legal guardian of

\_\_\_\_\_, do hereby give my consent for

(student's name)

Habif Medical Health Services to provide treatment to my child. Treatment may include ordering lab tests, blood work, or x-ray, prescribing medications, splints, braces, crutches, etc., referral to a specialist provider, emergency room, and/or, collaboration with other Washington University organizations.

I further understand that my signature does not imply authorization to release my child's health information to me and that I have the right to revoke this consent at any time.

In medical encounters involving pregnancy (but excluding abortions), sexually transmitted diseases, drug or substance abuse, I understand that parental consent is not required and permission to discuss these encounters would need to first be obtained from my child.

Parent/ Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please fax to Habif nursing at 314-696-1214 or email [habifnursing@wustl.edu](mailto:habifnursing@wustl.edu)