Habif Medical Health Services
Parental Consent Form

I, ________________________________, as legal custodial parent/legal guardian of

__________________________________, do hereby give my consent for

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