UNIVERSITY OF ARKANSAS

Medical Services Department

P: 479-575-4451 | F: 479-575-8793 | E: pwhc@uark.edu

Division of Student Affairs

Pat Walker Health Center

AUTHORIZATION FOR TREATMENT OF A MINOR

NAME: _____ **AGE:** _____ **SS#:** _____

MEDICATION/ALLERGIES: _____

1. **IS PATIENT TAKING MEDICATION ON A REGULAR BASIS?**

   ☐ Yes ☐ No *If yes, what?* _____

2. **IS PATIENT UNDER A DOCTOR'S CARE AT THIS TIME FOR ANY MEDICAL PROBLEM?**

   ☐ Yes ☐ No *If yes, for what?* _____

   PHYSICIAN NAME: _____ **PHONE:** _____

3. **DOES PATIENT HAVE ANY CHRONIC MEDICAL PROBLEMS? (ASTHMA, DIABETES, EPILEPSY, ETC.)**

   ☐ Yes ☐ No *If yes, what?* _____

4. **HAS PATIENT HAD CLOSE RELATIVE PASS AWAY FROM A HEART ATTACK BEFORE AGE OF 40?**
   ☐ Yes ☐ No

5. **DOES PATIENT HAVE A HISTORY OF A HEAD INJURY RESULTING IN A LOSS OF CONSCIOUSNESS?**

   ☐ Yes ☐ No *If yes, when?* _____

6. **DOES PATIENT HAVE A HISTORY OF MENTAL HEALTH PROBLEMS?**

   ☐ Yes ☐ No *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 Pat Walker Health Center professional staff.

NAME: _____ **HOME PHONE:** _____ **WORK PHONE:** _____
PLEASE PRINT

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____