UNIVERSITY OF ARKANSAS

Medical Services Department

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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:** ______________