



Consent for Medical Treatment for Minors

University of Chicago Hospitals
Primary Care Group/Student Care Center
5841 S. Maryland Ave., MC 3052
Chicago, IL 60637
(773) 702-4156

I hereby authorize the medical staff of The University of Chicago Hospitals Primary Care Group, the Student Care Center, and the University of Chicago Hospitals and Clinics to provide medical treatment for my daughter/son while she/he is or is not enrolled in educational programs at The University of Chicago for the period of time noted below.

Please print clearly and return this form to the Student Care Center via postal mail (see above address) or hand-delivery by your University of Chicago student.

Name of Minor: _____

Birthdate (day/month/year): _____

Through date of 18th Birthday (day/month/year): _____

Name of Parent/Guardian: _____

Relationship: _____

Address of Parent/Guardian: _____

Telephone of Parent/Guardian: _____

Signature of Parent/Guardian: _____

Today's date: _____