

**Parental/Guardian Consent for Students Who Are Minors**

1. **STUDENT INFORMATION**

First Name: Middle Name: Last (Sur/Family) Name:

Permanent Address:

*(Street and Number) (Apartment) (City) (State/Province) (Zip Code) (Country)*

Home Phone\*: Cell Phone\*:

*\*List numbers as they would need to be dialed from the U.S. to reach home country*

Email Address:

1. **PARENT/GUARDIAN’S INFORMATION**

Parent/Guardian’s Full Name (1):

Address:

*(Street and Number) (Apartment) (City) (State/Province) (Zip Code) (Country)*

Daytime Phone\*: Cell Phone\*:

*\*List numbers as they would need to be dialed from the U.S. to reach home country*

Email Address:

Does parent/guardian (1) speak English? □ Yes □ No

If no, please list the primary language(s) which parent/guardian (1) speaks:

*In the event of an emergency, Bellarmine staff may need to contact the parent/guardian of the student who is a minor. If the parent/guardian does not speak English, the University will do its best to find a translator who can communicate in the parent/guardian’s primary language(s).*

*(Optional)* Parent/Guardian’s Full Name (2):

Address:

*(Street and Number) (Apartment) (City) (State/Province) (Zip Code) (Country)*

Daytime Phone\*: Cell Phone\*:

*\*List numbers as they would need to be dialed from the U.S. to reach home country*

Email Address:

Does parent/guardian (2) speak English? □ Yes □ No

If no, please list the language(s) which parent/guardian (2) speaks:

*In the event of an emergency, Bellarmine staff may need to contact the parent/guardian of the student who is a minor. If the parent/guardian does not speak English, the University will do its best to find a translator who can communicate in the parent/guardian’s primary language(s).*

1. **CONSENT/AUTHORIZATION FOR TREATMENT**

I, declare that I am the of

*(Full name of parent/guardian) (Mother/Father/Guardian)*

, a minor, age , born . I grant

*(Full name of minor)* *(Month/Day/Year)*

permission to the professional staff of Bellarmine’s Health Services Clinic to evaluate and treat my minor child, listed in section A. I also give authorization to these professional staff to make referrals for evaluation or treatment to clinicians, physicians or other medical professionals/consultants/health services, as they deem necessary for the care of my minor child. Finally, I give authorization to Bellarmine’s Health Services Clinic staff to share with the necessary personnel or medical professionals information such as medical history and insurance information which would be considered important and necessary for treatment or evaluation.

I understand this permission is granted until the minor turns 18 years of age, or until I revoke this permission in writing.

Signature of parent/guardian: Date: