ASU HEALTH SERVICES
PARENTAL CONSENT FOR MEDICAL CARE FOR UNDERAGE ASU STUDENTS

Arizona law requires parental consent for medical, surgical, and psychiatric treatment of minors.

_IN ARIZONA, MINORS ARE INDIVIDUALS UNDER 18 YEARS OF AGE._

If your minor son or daughter will be enrolled as a student at Arizona State University, you are encouraged to complete and return the medical treatment form below.

Please mail or fax this form to your ASU health service:

<table>
<thead>
<tr>
<th>Location</th>
<th>Address</th>
<th>Phone Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tempe: ASU Campus Health Service</td>
<td>Tempe, AZ 85287-2104</td>
<td>Fax: 480.965.6531</td>
</tr>
<tr>
<td>Polytechnic: ASU Student Health</td>
<td>Mesa, AZ 85212</td>
<td>Fax: 480.727.1599</td>
</tr>
<tr>
<td>West: ASU Health Center</td>
<td>Phoenix, AZ 85004</td>
<td>Fax: 602.543.8079</td>
</tr>
<tr>
<td>Downtown Phoenix: ASU Health Center</td>
<td>Phoenix, AZ 85069</td>
<td>Fax: 602.496.0675</td>
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CONSENT TO MEDICAL TREATMENT

Please type or print.

Student, (name) ________________________________ ASU ID # ______-______-______, date of birth _______/_____/______.

I, (name) ________________________________________________, am the parent or legal guardian of the minor student above.

_I hereby consent to the performance of medical or minor surgical treatment by Arizona State University health services medical staff on my son or daughter while he/she is an Arizona State University student._

Parent/Legal Guardian Name _____________________________________________________________

Address ______________________________________________________________________________

______________________________________________________________________________

Emergency Phone: Home (_____ ) _________________________ Work (_____ ) _________________________

Parent/legal guardian signature _______________________________________ Date __________