



**American University**

**Student Health Center**

**Consent to Treat Minor Patients**

District of Columbia law requires consent of a parent / legal guardian for medical care of minors. If your son or daughter is enrolled at American University prior to his / her eighteenth birthday and they seek care at the Student Health Center, you must complete and return the following consent to:

Student Health Center  
American University  
4400 Massachusetts Avenue, NW  
Washington, DC 20016-8036

**Consent for Medical Treatment**

I, \_\_\_\_\_ (print name here), am the parent/legal guardian of

\_\_\_\_\_ (print name of student), currently a minor, whose date of birth is \_\_\_/\_\_\_/\_\_\_.

I authorize the American University Student Health Center to provide medical care to my son/daughter, including, but not limited to diagnostic examinations (including laboratory testing), tuberculosis screening, verification and/or administration of immunizations and necessary medical treatment.

I understand that once my child reaches the age of majority, my consent for treatment is no longer required.

By signing this, I acknowledge that I have read and that I understand this consent, and that any questions I had prior to signing could be answered by calling the Student Health Center at 202.885.3380.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Emergency Phone: Home ( ) \_\_\_\_\_  
Cell ( ) \_\_\_\_\_

Work ( ) \_\_\_\_\_