UNIVERSITY OF ILLINOIS

COLLEGE OF MEDICINE AT ROCKFORD

PERMISSION FOR MINOR TO RECEIVE MEDICAL CARE

PATIENT LABEL HERE

☐ F.W. Shappert Primary Care Clinic at Belvidere 815.547.5461	☐ Student Health & Wellness at Parkview 815.395.5870
☐ University Children's Health Center 815.637.0000	☐ SBHC at South Beloit (Junior High School) 815.389.9252
☐ Primary Care Clinic at Rockton 815.624.2644	☐ SBHC at South Beloit (High School) 815.389.9252
☐ Family Health Center 815.972.1000	☐ Blackhawk Park School Linked HC (Rockford) 815.395.5858
☐ University Outreach Services at Rochelle 815.562.6976	

I give permission for my minor child to receive medical care in my absence at University of Illinois College of Medicine at Rockford Clinics, as follows:

______________________________ ______________

Name of Child/Minor Date of Birth

1) **Child may present for Clinic services on their own.** **Yes** **No**

2) **Consent to treat may be furnished by someone other than parent.** **Yes*** **No**
***If yes, identify below the person(s) who may grant consent to treat.**

Name	Relationship to Minor

This permission to treat will remain in effect unless revoked by the parent/guardian.

______________________________ ______________

Signature of Parent/Guardian Date

______________________________ ______________

Signature of Witness Date