UF | Human Resources
UNIVERSITY of FLORIDA

Parental/Guardian Authorization for Volunteer Service & Treatment of Minors

Section 1 – PARENT/GUARDIAN APPROVAL

As the parent/guardian of the above-identified volunteer who is under 18 years of age, I grant my permission for the above-identified volunteer to participate as an unpaid volunteer for the University of Florida. I further acknowledge that I have completed the Authorization for Treatment on his/her behalf (Sections 2-3 of this document).

Parent/guardian: _____ _____ _____
Print name Signature Date

Section 2 – TREATMENT AUTHORIZATION

I authorize the provision of medical or hospital care deemed necessary for:

Volunteer Name: _____ ☐ Male ☐ Female
First Middle Initial Last

Date of Birth: _____

In the event an illness or injury occurs during his or her volunteer service to the University of Florida, I further authorize each of the following:

- I grant permission to the treating physician or other health care providers to employ such diagnostic procedures and medical treatment as deemed necessary.
- I authorize all medical care units to release medical record information to the University's workers' compensation health care provider and insurance carrier in order to process claims.

I understand that I am financially responsible for charges not covered by the University or insurance and hereby guarantee full payment to the physicians or health care units.

Section 3—PHYSICIAN/EMERGENCY CONTACT INFORMATION

Family Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Preferred Local Hospital: _____

Section 4—PARENT/GUARDIAN INFORMATION

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

Signature: _____ **Date:** _____

Name of Parent or Guardian: _____

Home Phone #: _____ Work Phone #: _____

Address: _____

Signature: _____ **Date:** _____

Note to Department: This form should be uploaded to ePAF.

Section 5—TO BE COMPLETED BY THE DEPARTMENT

Department documentation for telephone authorization

Person Contacted: _____ Phone: _____

Relationship to Volunteer: _____ Phone: _____

Witnesses: _____ Phone: _____

Description: _____

_____

_____

Date: _____ Time: _____

Note to Department: This form should be uploaded to ePAF.