

**TO BE FILLED OUT IF UNDER 18 YEARS OF AGE  
(MEDICAL RELEASE FOR TREATMENT OF A MINOR)**

Social Security Number: \_\_\_\_\_

**PROGRAM**

(check one):

S.H.A.R.P.

Student Volunteer

Student Aide

Other (Explain): \_\_\_\_\_

The following completed consent form will be filed with the individual's health record. While completion of this form is voluntary, physical examinations and medical care (other than emergency) will be withheld without the appropriate signatures.

We hereby authorize the Marshall Space Flight Center (MSFC) Medical Center and such physician or physicians in charge of the care of the minor listed below, to furnish medical care, including physical examinations and emergencies, within the capabilities of the Medical Center as provided to MSFC personnel.

Name of Minor: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Minor's Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Parent's or Guardian's Signature: \_\_\_\_\_

Relationship to Minor: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Witnesses' Signature: \_\_\_\_\_

Date Signed: \_\_\_\_\_

This form is subject to the Privacy Act of 1974.

Written consent of parent or legal guardian shall be obtained prior to treatment of minors. State law shall govern in establishing the legal age. This covers the part-time students employed under provisions of the Special Programs Authority.

MSFC Program Coordinator: \_\_\_\_\_ Phone: \_\_\_\_\_