

Student Health and Counseling Center

P.O. Box 755580, 1007 N. Chandalar Drive

Street Address Line 2	2			
Your child/stud	lent's name *			
FirstName	LastName			
Your child/student's date of birth *				

Please select the services you are consenting for your child/student to receive from UAF SHCC. *

Counseling/psychological diagnostic and treatment services Acute and primary medi

Street Address

Month Day Year

By signing this form, I acknowledge that I have b