[redacted]

Student Health and Counseling Center

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

Street Address

Street Address Line 2

Your child/student's name *

First Name Last Name

Your child/student's date of birth *

Month Day Year

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
-
-

By signing this form, I acknowledge that I have b

- ○
- ○