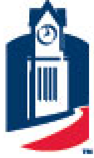

CONSENT FOR MEDICAL TREATMENT OF A MINOR

(Information and Consent)

Name of Minor: ____ Date of Birth: _________________

Address (Street, City, State, Zip Code): ____

____

Parent/Guardian Phone number (with area code): ____
Home: ________________________ Cell: ____________________ Work: ____________________
Other contact person: ___________________________________Phone # _______________________

I, _________________________________natural parent/legal guardian of _____________________ (a minor), give my consent for medical and/or surgical treatment of this minor by a licensed health care professional, should the need arise while he/she is attending Columbus State University. I understand that medical personnel will make reasonable attempts to contact me before initiating treatment. I am aware that the practice of medicine is not an exact science and that no guarantees can be made concerning the results of treatment. I grant permission for treatment provided according to generally accepted standards of medical practice. This consent will be in effect from this date until minor is **18 years of age** unless cancelled earlier by me in writing.

____ ___________________
Signature of Parent/Legal Guardian Date

____
Print Name

Medical Information related to Minor:

Allergies: ____

Current Medications: ____

Date of Last Tetanus Booster: ____

Pertinent Medical History: ____

____

Columbus State University Student Health Center
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