



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: _____
