COLUMBUS STATE UNIVERSITY

Student Health Center

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 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

_____ Student 909#: _____
Print Name

Medical Information Related to Minor

Allergies: _____

Current Medications: _____

Date of Last Tetanus Booster: _____

Pertinent Medical History: _____

_____

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