CONSENT FOR MEDICAL TREATMENT OF A MINOR

(Information and Consent)

Name of Minor:_______________________________________ Date of Birth:_____________________________

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

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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

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Print Name

Medical Information related to Minor:

Allergies:____

Current Medications:____

Date of Last Tetanus Booster:____

Pertinent Medical History:____

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Return signed and dated form to the following address:

Columbus State University
Student Health Services
4225 University Avenue
Columbus, Georgia 31907

Columbus State University
University Health Services