Health Center at AURARIA

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Consent for Treatment of a Minor

1. PATIENT INFORMATION

Patient Name (First name, middle initial and last name)		**Today's Date** MONTH DAY YEAR
Social Security Number	**Student ID#**	**Date of Birth** MONTH DAY YEAR

2. PARENT/GUARDIAN INFORMATION

Parent/Guardian Name	**Relationship to Patient**
Current Address (Number, street & apt or suite number)	
City, State and ZIP Code	
Home Phone (Required)	**Secondary Phone** (Required)

Secondary Emergency Contact Name	**Relationship to Patient**	**Phone Number**

By signing below, I agree that being the parent or legal guardian of the patient listed above, give my consent for both emergency and routine medical and surgical treatment of this minor at the Health Center at Auraria should their condition so require it as deemed necessary by a HCA health care provider. I understand that in the case of an emergency, reasonable attempts would first be made to contact me, time and conditions permitting. As long as the medical or surgical treatment considered necessary in the situation, is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitations or prohibitions regarding treatment other than those that follow: (if none, so state)

I understand that this authorization is good until the time in which the minor mentioned above reaches his/her 18th birthday.

Parent/Guardian Signature	**Date** MONTH DAY YEAR
Witness	**Date** MONTH DAY YEAR