



## Consent for Treatment of a Minor

1. PATIENT INFORMATION		
Patient Name (First name, middle initial and last name)		Today's Date <small>MONTH DAY YEAR</small>
Social Security Number	Student ID#	Date of Birth <small>MONTH DAY YEAR</small>
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
<p>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 Health Center at Auraria 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)</p>		
<p><b>I understand that this authorization is good until the time in which the minor mentioned above reaches his/her 18th birthday.</b></p>		
Parent/Guardian Signature		Date <small>MONTH DAY YEAR</small>
Witness		Date <small>MONTH DAY YEAR</small>