***CHADRON MEDICAL CLINIC, P.C.***

***CHADRON STATE COLLEGE HEALTH SERVICES***

CONSENT TO TREAT MINOR CHILD (consent is required for all students under age 19)

Please Print all Information

I, Parent or legal guardian of \_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student)\_ birthdate / / do hereby consent to any medical care and to the administration of anesthesia determined by a physician to be necessary for the welfare of my child while said child is a student enrolled at Chadron State College and I am not reasonably available by telephone to give consent.

This authorization is effective from 08/1/2024 to 05/31/2025 .

Signature of Parent or Legal Guardian

Witness Signature Witness Name (please print)

 Additional Information below will assist in treatment if it can be furnished with the consent but is not required.

***This consent form should be provided to Chadron Medical Clinic, P.C. and will be kept in patient’s medical record.***

Family Address

Telephone: Father Home Work

 Mother Home Work

Child’s Birthdate Last Tetanus

Allergies to drugs of foods

Special Medications, Blood Type or Pertinent Information

Child’s Physician Phone

Insurance Policy #

Preferred Hospital