



CONSENT TO TREAT A MINOR STUDENT

STUDENT INFORMATION

Name & Address: _____

Date of Birth _____ Gender: _____ Male _____ Female

Parent/Legal Guardian's Name & Email _____

Street Address _____

City State Zip _____

Home, Work and Cell Phone _____

AUTHORIZATION FOR MEDICAL CARE

I, _____, parent or legal guardian of _____,

DOB: _____, do hereby consent to any medical care and the administration of anesthesia determined by a physician to be necessary for the welfare of my minor child while said child is attending Howard Payne University and accompanied and/or transported by the designated staff of HPU.

SIGNATURE IS REQUIRED:

Student's Name (printed) Date

Parent/Legal Guardian's Signature Date

Notary Signature Notary Stamp

A PARENT OR GUARDIAN MUST SIGN THIS FORM FOR A MINOR UNDER THE AGE OF 18

******Please provide a copy of the front and back of the Student's current Insurance Card & Responsible Party**

Info.****

This Consent Form should be taken with the Student to the Hospital or Physician's Office when the Student is taken for treatment.

Feb.2014