



# CONSENT FOR TREATMENT OF A MINOR

**Please print:**

Name of Minor: \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_

Home Address: \_\_\_\_\_

Street

City

State

ZIP code

Parent/Guardian Phone Number: \_\_\_\_\_ Circle one: Home Work Mobile

I, the undersigned, as the parent or legal guardian of \_\_\_\_\_ (a minor), hereby authorize such diagnostic, medical and/or surgical treatment of such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and Gutenberg College and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

## Medical Information Related to Minor:

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Date of Last Tetanus Booster: \_\_\_\_\_

Pertinent Medical History: